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Increasing Permanent Home Placements for Children With Diagnosed Disabilities in Foster Care

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Abstract

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MPH, Tulane University, School of Public Health & Tropical Medicine, 1991

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Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
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Abstract

In the United States, 397,000 children received foster care services in 2012. Some states successfully achieved permanent homes for children with diagnosed disabilities who exited care while others were less successful. Using change theory and social ecological theory as the foundations, the purpose of this study was to determine the impact that diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between ages of 0 to 6 years in 2012. Hernandez's and Hodges's theory of change was used to evaluate the 1982 standards that license foster care agencies, while Stokol's ecological theory provided the framework to assess whether there were measurable increases in child welfare outcomes for permanent placements among children with diagnosed disabilities. Following a retrospective, nonexperimental, quantitative design, data were acquired from a purposive sample of 344 archived foster care files across the state. These data were analyzed using bivariate correlation procedures to evaluate the strength of the relationship between medically diagnosed conditions and permanent placement. The findings indicated a statistically significant association between medically diagnosed conditions and permanent placements ($p=0.01$). Additionally, length of stay in care was also found to be statistically associated with permanent placement ($p=0.019$). The theoretical constructs evaluation with a theory of change found the 1982 standards were outdated to authorize the licensing of foster care agencies; the social ecological theory identified evidence for change to achieve the intended goal. Findings of this study may provide guidance to policymakers in term of improving standards related to oversight and licensing foster care agencies in order to better support permanent placement of children with disabilities.

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Dedication

"We gain strength, and courage, and confidence by each experience in which we really stop to look fear in the face … we must do that which we think we cannot" (Roosevelt, 1960, p. 29). Guided by the words of the late Mrs. Roosevelt, I dedicate this study to my mother, the late Mrs. Hazel Isabel Smith, who passed away on December 15, 2011. I thank her for the breath of life and for instilling in me the value of a solid education at an early age, for expecting only the best from me and not settling for anything less, and for making me realize that I should not settle for silver when gold is within my reach. Knowing that, through my faith in God I gained strength, courage, and confidence to do what I thought I could not. I hope that within the words of this dissertation I have offered considerations for a social change that will lead to increasing permanent placement in foster care for children discharged with diagnosed disabilities.

Acknowledgments

The completion of my dissertation in many ways was a joint effort of many individuals who provided direction and support during my study. I must begin by expressing how grateful I am for the support provided to me by the members of my dissertation committee. My profound thanks go to Dr. Kristie Roberts, who served as my committee chair and one of my first instructors at Walden. A special thanks to Dr. Lori Demeter, committee member and mentor throughout my Walden journey. I also thank Dr. Wendy Andberg and Dr. Lynn Wilson, University Research Reviewers who guided the final product of my dissertation to achieve its highest quality. The support from my chair and committee members encouraged my pursuit of this dissertation even when tragedies in my life were far too much to bear; my husband's accident that left him a paraplegic, my eldest son on life support during a two-month critical care hospitalization, and the death of my mom, the late Mrs. Hazel Isabel Smith.

To my husband and chief supporter Denis, our hearts beat as one. Thanks for keeping my expectations high and reminding me of the great reward at the end of this journey. Special thanks to my children Ukachukwu, Kelechi, and Udochi; my sisters Marcia, and Christine, and some close friends Deborah, Linda, and Vanessa who kept cheering me along. Thanks for walking the walk with me and giving me encouragement to complete this dissertation. I am also indebted to staff at the National Data Archive for Child Abuse and Neglect and Pennsylvania's state government for their guidance.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

In the United States, the term *foster care* commonly refers to services rendered by child protective service agencies after they remove a child from the custody of the parent or guardian and place that child in another person's care. Child protective services may put children in foster care for some time to protect the children from harmful situations such as abuse or neglect U.S. Department of Health and Human Services Administration for Children, Youth and Families [US DHHS ACYF] Children's Bureau, 2012e). For children placed in foster care, the service is usually meant to provide a temporary safe residence; consequently, a plan for a permanent living arrangement is required when the child is being discharged from care (US DHHS ACYF Children's Bureau, 2012e). Although Simms, Dubowitz, and Szilagyi (2000) noted that the 1933 Title IV of the Social Security Act was established to help fund state-supported nonrelatives foster home, it seems evident that before the 1960s, foster care was not popular due to the lack of awareness in the general population. Simms et al. continued noting that the 1960s brought a dramatic increase in children entering foster homes due to increasing public awareness of child abuse and maltreatment. Simms et al. also indicated that by the late 1970s, little efforts were in place to return children to their biological caregivers or to plan for adoptions.

Stalker and McArthur (2012) assessed academic journals that reviewed research about child abuse, child protection, and disabled children between 1996 and 2009. Their assessment determined that planning for a permanent living arrangement is a significant problem facing all children in foster care. In 1980, the Child Welfare Reform Act (PL 96-272) directed social services to prevent out-of-home placements when possible, to make reasonable efforts to reunify them with their biological families when feasible or to find adoptive placement when necessary. My review of the academic literature suggested that a strong association exists between disabilities and child maltreatment. Stalker and McArthur (2012) asserted that disabled children were significantly more likely to experience abuse when compared to their nondisabled peers. Stalker and McArthur's work also determined that children with communication, behavioral, learning, and sensory impairments have increased vulnerability to abuse. Furthermore, Stalker and McArthur noted that boys experienced all categories of maltreatment and that more girls were sexually abused compared to boys. Stalker and McArthur's research found that a complicated and inconsistent pattern was evident among abused disabled children and that disabled boys were overrepresented in all categories of maltreatment including sexual abuse. Stalker and McArthur noted that gender was not a predictor of physical abuse or neglect; however, more girls than boys were sexually abused.

Stalker and McArthur (2012) continued to note that there were no standard approaches found to protect disabled children in the United States and that developmental and medical problems resulted in more extended stays in foster care. Their concern was that more extended stay in foster care could result in lower rates of return to parental responsibility. Stalker and McArthur added that there are higher numbers of children retained in foster care placements, especially among disabled children. According to Freundlich (2010), when families are supported and strengthened, children often can remain safely with their families and in communities to grow and thrive. Thus, legislative strategies to prevent or reduce out-of-home placement, such as family support and family preservation services, can be used as a source of protection for children.

A report by the Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition (2003) stated that since the "passage of the Adoption and Safe Families Act (ASFA) of 1997, Congress mandated that child welfare agencies take steps to ensure children's health as well as their safety and permanence" (p. 1). Consequently, priority was given to promote healthy outcomes for children in substitute care, assuring timely access to high-quality health care, early intervention, and behavioral health services to improve the well-being of and stable placements for children (Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition, 2003). The subcommittee's report highlighted the results of a pilot study from Philadelphia's Department of Public Health on the health status of 100 children in substitute care. The report findings revealed that 56% of children aged 2 to 19 years had a diagnosed chronic medical condition, 55% had allergies, and 24% had mental health problems or mental retardation issues.

These results from the Philadelphia Department of Public Health necessitated the development of practical guidelines to promote healthy outcomes and reduce barriers to health care for children in substitute care (Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition, 2003). For instance, the subcommittee outlined strategies for use by the courts and child welfare professionals that would support the healthy development of children as well as comply with federal mandates to improve outcomes, promote permanent residence, and support families of children in foster care. Similarly, the US DHHS ACYF Children's Bureau (2010a) encouraged improvements in health to provide for the safety, permanency, and well-being of children and families served through the foster care system. The Children's Bureau indicated that their focus is on strengthening families, preventing child abuse and neglect, protecting children when abuse or neglect has occurred, as well as ensuring that every child and youth has a permanent family or family connection. The significance of the research conducted by the Children's Bureau led to the formation of the Child Abuse Prevention and Treatment Act (CAPTA; 42 U.S.C. §5101), as amended by the CAPTA Reauthorization Act of 2010 (US DHHS ACYF Children's Bureau, 2013). The US DHHS ACYF Children's Bureau (2013) noted that CAPTA is a positive change, as its vision as it retained the existing definition of child abuse and neglect that was established to address at a minimum:

> Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm. (p. ix)

The US DHHS ACYF Children's Bureau reported that case-level data from the National Data Archive on Child Abuse and Neglect showed that over 3 million children had at least one report of maltreatment and received one or more interventions in the federal fiscal year (FFY) 2012. For the same year, an estimated 686,000 of these children received child abuse and neglect supportive services substantiated reports of maltreatment. The US DHHS ACYF Children's Bureau also reported that, among those children, 146,000 received foster care services, and 233,000 children were provided services within their homes. Additional results from this national report found three common types of maltreatment: 78.3% of children maltreated had suffered neglect, 18.3% had experienced physical abuse, and 9.3% had suffered sexual abuse (US DHHS ACYF Children's Bureau, 2013).

The US DHHS ACYF Children's Bureau (2014) added that federal and state governments had begun taking steps to ensure children's health by improving the child welfare system to make states to become more accountable for child welfare outcomes. This report prompted my review of Pennsylvania's licensing code policy, to determine whether standards were in place to increase permanent placements for children with diagnosed disabilities and who were discharged from foster care. The remaining sections in this chapter will include a general overview of the background, problem statement, purpose, research question and hypotheses, theoretical framework, assumptions, limitations, and significance of this study.

Background of Study

The commonwealth of Pennsylvania's Code for Public Welfare Title 55 sets standards that authorize the licensing of foster care placement agencies and facilities, both public and private (Commonwealth of Pennsylvania Code, 1982). The standards that govern foster family care for children placed by an approved foster family care agency were written broadly to describe the requirements that must be adhered by county and statewide service agencies. The Pennsylvania Department of Public Welfare, Office of Children, Youth, and Families (2009) encouraged the uniformity of programs and policies governing kinship care for children placed in homes of relatives. The enactment of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351) offered strategies to help keep families together and improve children's health outcomes. For example, the Fostering Connections Act established the federal Title IV-E Guardianship Assistance Program to make federal dollars available for more children exiting foster care to have access to permanent homes with families and relative guardians when appropriate (Collaborative Project of the Children's Defense Fund, 2012). The Guardianship Assistance Program also encourages consistency with regulations governing foster care agencies (Collaborative Project of the Children's Defense Fund, 2012).

As I indicated earlier, the commonwealth of Pennsylvania Code provision that guides foster care placement agencies was written quite broadly, and at the time of this study, it has not been updated since July 23, 1987, when the standards were enacted (Commonwealth of Pennsylvania Code, 1982). An updated provision could provide current and necessary steps to guide foster family care agencies on ways to improve child welfare outcomes and in the same way that recommendations are made to the U.S. Congress. The US DHHS ACYF Children's Bureau (2014) noted that the annual *Child Welfare Outcomes Report* to Congress contains critical information on the process of improving outcomes for children and families that could be a resource to Pennsylvania's code that governs the licenses of placement agencies.

In another provision, the requirement for foster family residence to become an approved foster family was last updated on January 24, 1987 (Commonwealth of

Pennsylvania Code, 1982). This means that the provision in place through the commonwealth of Pennsylvania Code that governs the licensing of foster care agencies seems outdated. The current provisions state that the Pennsylvania Code for licensing foster care agencies is to: (a) reduce risk to foster children in placement; (b) protect the health, safety, and rights of foster children; (c) establish minimum requirements for the operation of a foster family care agency; and (d) establish minimum requirements to approve and supervise foster families (Commonwealth of Pennsylvania Code, 1982). To ensure that overall health and safety conditions are in place, the Commonwealth of Pennsylvania Code (1982) gives authorization for foster family care agencies to inspect residences for compliance in health-related requirements and licensed physicians to conduct medical assessments within 60 days of the child's admission to foster family care. The assessment is to include a review of the child's health history, a physical examination, laboratory or diagnostic tests to detect communicable disease, and arrangement of immediate medical attention if a medical problem is recognized (Commonwealth of Pennsylvania Code, 1982).

The commonwealth of Pennsylvania Code that governs the licensing of foster care agencies does not address standards to achieve and maintain permanent placements for children with diagnosed disabilities and who are discharged from foster care. Looking at a national level, the US DHHS ACYF Children's Bureau (2014) defines increased permanency as obtaining and maintaining a permanent home for children in foster care within their families of origin or with other stable families. The US DHHS ACYF Children's Bureau reported that some states were successful in obtaining permanent homes for children leaving foster care in 2012, while others were less successful in obtaining permanent homes for children who have diagnosed disabilities. Additionally, the Children's Bureau reported that states were even less successful in finding permanent homes for children who were older than age 12, or have been in foster care for 24 months or longer. The 2012 data from states showed that 87.3% of children had permanent homes by the end of the year, while only 77.7% with diagnosed disabilities had a successful placement (US DHHS ACYF Children's Bureau, 2014). This finding is significant as this study showed whether Pennsylvania's archived data reveals success in obtaining permanent homes for children who have diagnosed disabilities and were leaving foster care.

Federal child welfare outcomes data showed that Pennsylvania's FFY 2012 report had an estimated number of 14,862 foster care children statewide who are receiving child protective services (US DHHS ACYF Children's Bureau, 2014). This report is of concern to me in this study considering that the entry rate into foster care for Pennsylvania was 3.7 children per 1,000 in 2012. At the same time, the US DHHS ACYF Children's Bureau (2014) also reported that the national entry rate into foster care ranged from 1.3 children per 1,000 to 8.6 children per 1,000 of Pennsylvania's population. Similarly, a report from the Task Force on Health Care for Children in Foster Care (2005) noted that children and adolescents entering the foster care system have higher occurrences of behavioral, developmental, and other health conditions compared to groups of children outside of the system. Also, the task force reported that children entering foster care were more predisposed to chronic and persistent health conditions that led to an accumulation of unpleasant events and unmet needs. Improved coordination of services is needed to address behavioral, developmental, dental, and health conditions among children in foster care should be aligned with national healthcare financing standards to support child welfare goals relative to health, safety, and permanency (Task Force on Health Care for Children in Foster Care, 2005).

According to the Child Welfare Information Gateway (2012a), states have primary responsibility for child welfare services and were entrusted to have the legal and administrative structures as well as programs to address the needs of children and families. The Child Welfare Information Gateway emphasized that states are also mandated to comply with specific federal requirements and guidelines to be eligible for federal funding used for child protection, welfare, and adoption services. For example, the enactment of the CAPTA in 1974 provided financial assistance for demonstration programs that offered identification, prevention, and treatment of child abuse and neglect. These federal requirements addressed a gap in knowledge and provided a further understanding of the factors that support or inhibit permanent placements of Pennsylvania’s children who have diagnosed disabilities and were leaving foster care.

The Child Welfare Information Gateway (2012a) cited the Child and Family Services Improvement and Innovation Act of 2011 as being responsible for extending child and family services program through the 2016 federal fiscal year. This act allowed states to have oversight and coordination of health care services for any child in foster care who is receiving treatment for emotional trauma associated with maltreatment and removal from home and also provided protocols to guide the appropriate use and monitoring of psychotropic medications (Child Welfare Information Gateway, 2012a). Additionally, states' child welfare services plans were to describe "activities to reduce the length of time children under the age of 5 are without a permanent family," as well as "activities to address the developmental needs of such children who receive benefits or services" (Child Welfare Information Gateway, 2012a, p.4). The provision of this act was significant for this study as it offered essential improvements that the commonwealth of Pennsylvania Code governing the licensing of foster care agencies could use to extend child welfare and family services plans.

The Child Welfare Information Gateway (2012b) noted that states' laws are in place so that child welfare agencies can make reasonable efforts to address the conditions that keep children in foster care for extended periods of time. The Child Welfare Information Gateway added that state laws encouraged activities that support reasonable efforts and that consist of accessible, available, and culturally appropriate services to improve the capacity of families to provide safe and stable homes for their foster care children. The services provided by states may include home visits and support groups that promote having a legal, permanent, nurturing family for every child from out-of-home care through family reunification, adoption from foster care, guardianship, and permanent placements with relatives (Child Welfare Information Gateway, 2012b). The Child Welfare Information Gateway noted that Pennsylvania has a state-supervised, county-administered child welfare system and that the capacity to collect data and monitor activities through a statewide information system may be limited.

The US DHHS ACYF Children's Bureau (2010b) identified several improvement areas in 2007 data on state performance outcome measures. The US DHHS ACYF Children's Bureau presented outcome measures that reduced incidence and recurrence of child abuse and neglect, increased permanent placements for children in foster care, reduced time spent from foster care to reunification without increasing reentry, increased reunification with family, reduced reentry, and increased placement stability. The 2007 performance outcomes also showed that states were successful in obtaining and maintaining permanent placements of children in foster care (US DHHS ACYF Children's Bureau, 2010b). The Children's Bureau noted that there are achievements in the attainment of permanent home placements for all children discharged from foster care, considering that 86.9% of the children were placed. From this success, it was determined that less time spent in foster care is the result of sustained reunification with family as well as decreased reentry back to foster care (US DHHS ACYF Children's Bureau, 2010b). There were stable and appropriate placements found for 68% of children who spent fewer than 12 months in foster care (US DHHS ACYF Children's Bureau, 2010b). However, the Children's Bureau noted that placement stability declines considerably with the prolonged time that the children remained in foster care.

The decline in placement stability provided significant additional support for this study, considering that I could identify no literature that addressed whether Pennsylvania's children with diagnosed disabilities who are discharged from foster care have achieved increased placement stability to a permanent residence. My hope was that the outcomes from this study could augment the current state rules and regulations for

Pennsylvania's licensing code policy. Consequently, in this study, I examined the impact that diagnosed disabilities have on permanent home placements and recommend strategies to improve placements and national performance standards.

Problem Statement

While some children exiting foster care in Pennsylvania experienced successful placements in 2012, there were fewer successes were reported in the placement of those children identified as having diagnosed disabilities (US DHHS ACYF Children's Bureau, 2014). The problem I addressed in this study was that no evidence had been identified to suggest whether Pennsylvania's licensing code policies that govern foster family agencies have initiatives in place to increase permanent home placement for children with diagnosed disabilities who are discharged from foster care. In 2012, the US DHHS ACYF Children's Bureau (2014) reported estimates that 252,000 children entered foster care placements, while 241,000 children exited foster care throughout the United States. The Children's Bureau added that the number of children in foster care had decreased by 24.2 % between 2002 and 2012, from 524,000 to 397,000. According to the US DHHS ACYF Children's Bureau, these reductions were a result of efforts by states to safely reduce the number of children in care through various programmatic and policy initiatives. While the *2012 Child Welfare Outcomes Report* stated that there continued to be a downward trend in the number of children in foster care, the report noted that more efforts are needed to track that critical information to determine the factors contributing to the decrease (US DHHS ACYF Children's Bureau, 2014).

In Pennsylvania, children entered foster care at a rate of 3.7 children per 1,000 of the state’s population in 2012 (US DHHS ACYF Children’s Bureau, 2014). During that year, an estimated 14,862 Pennsylvania children received foster care services (US DHHS ACYF Children’s Bureau, 2014). Both the Task Force on Health Care for Children in Foster Care (2005) and the US DHHS ACYF Children’s Bureau (2014) reported that children in foster care with diagnosed disabilities are more predisposed to persistent health conditions, making it more difficult to place them in permanent homes placements. While there are available data indicating that persistent health conditions can affect permanent home placements (US DHHS ACYF Children’s Bureau, 2014), I identified no evidence in the literature to suggest Pennsylvania’s licensing code policies governing foster family care agencies had federal and state policies to address these concerns. Thus, it was necessary for me to examine data on each variable reported and describe the effects that the independent variable (diagnosed disabilities) had on the dependent variable (permanent home placements) among Pennsylvania’s foster care children who were discharged and who were between ages 0 to 6 years in 2012 in this study.

A review of the literature may offer ways to improve outcomes for children being served in foster care across child welfare agencies. Additionally, federal data reporting systems have guidance for collecting and reporting national and state performances in seven outcome categories (US DHHS ACYF Children’s Bureau, 2014). Since 1998, national performance objectives have been in place to guide the collection of state data to increase permanent home placements for children exiting foster care, including those identified as having diagnosed disabilities (US DHHS ACYF Children’s Bureau, 2014).

Efforts to improve outcomes for permanent placements for children with disabilities come in response to reports showing that children in foster care are more predisposed to persistent health conditions than the general population of children in the United States (Task Force on Health Care for Children in Foster Care, 2005). With widespread support for further interventions to improve child welfare outcomes, the use of federal and state standards already in place can increase permanent placements for children identified as having diagnosed disabilities and who are discharged from foster care (US DHHS ACYF Children's Bureau, 2010b, 2014).

Since the US DHHS ACYF Children's Bureau's (2005) initial report to Congress that provided information on performances conducted across states, there has been increasing use of performance measurement in child welfare to improve services and outcomes for children and families. The US DHHS ACYF Children's Bureau wrote that among the many performance measurements, permanency planning of children in foster care has been a primary child welfare system goal since passage of the Adoption Assistance and Child Welfare Act of 1980 P.L. 96–272. To effectively address permanent residency measures, the US DHHS ACYF Children's Bureau stipulated that states were to make reasonable efforts to prevent children from leaving their homes and make it possible for those in foster care to return home. States were also encouraged to place children in the least restrictive setting and that adoption assistance payments should be available to families who care for children with special needs, including diagnosed disabilities (US DHHS ACYF Children's Bureau, 2005). The importance of using performance measurements in child welfare to improve services and outcomes for children and families has been well documented (Task Force on Health Care for Children in Foster Care, 2005; US DHHS ACYF Children’s Bureau, 2005, 2010b, 2014). However, I identified no research that considered how these standards relate to Pennsylvania’s licensing code policies governing foster family care agencies, so it was a meaningful gap in the literature that I addressed in this study.

Purpose of the Study

The purpose of this study was to determine whether standards established for Pennsylvania in 1982 identified evidence of whether state licensing code policies were able to determine the relationships that diagnosed disabilities have on and permanent placements. To address this concern, I used a retrospective, nonexperimental quantitative design to assess the problem statement. My intent was that the results could be used to describe ways that evidence can focus on placement stability for children with disabilities who are in foster care. I used archived data from a federal child abuse and neglect site for secondary analysis to develop an in-depth understanding of the effects that the independent variable (diagnosed disabilities) had on the dependent variable (permanent home placements) among covariates, such as Pennsylvania’s foster care children who were discharged and who were between ages 0 to 6 years in 2012. The implications for positive social change as a result of the study include improving the standards used by Pennsylvania to authorize the licensing of foster care agencies and advancing knowledge in the discipline for future policies focusing on permanent placements for children with disabilities who are in foster care.

According to Muijs's (2011) definition, taken from Aliaga's and Gunderson's (2000) work, quantitative research is "explaining phenomena by collecting numerical data that are analyzed using mathematically based methods (in particular statistics)" (p. 1). The dependent variable for this study was permanent placements, while the independent variable was diagnosed disabilities, and the covariate variables, such as children between the ages of 0 to 6 years, were predictive of the outcomes of this study. I carefully analyzed and interpreted the values of each variable to show whether diagnosed disabilities have an impact on permanent home placements among Pennsylvania's foster care children.

Research Question and Hypotheses

In this study, I utilized data on each variable reported and the effects that the independent variable (diagnosed disabilities) had on the dependent variable (permanent home placements). I collected state data on each variable to improve child welfare from national and individual states' performances in seven outcome categories for this analysis (US DHHS ACYF Children's Bureau, 2014). My purpose was to identify evidence to suggest whether Pennsylvania's licensing code policies had initiatives in place to increase permanent home placement for children with diagnosed disabilities in foster care. I developed the following research question (RQ) and hypotheses to guide this study:

> RQ: What impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012?

H_0- There was no statistically significant impact that children with diagnosed disabilities had on permanent home placements among Pennsylvania’s foster care children who were discharged and were between the ages of 0 to 6 years in 2012.

H_A- There was statistically significant impact that children with diagnosed disabilities had on home placements among Pennsylvania’s foster care children who were discharged and were between the ages of 0 to 6 years in 2012.

The types of policy initiatives most helpful to increase permanent home placements have been in place since the mid-1980s (US DHHS ACYF Children’s Bureau, 2014). For this study, I analyzed and interpreted data to show the extent to which patterns might emerge and were represented by numerical or statistical results (see Belli, 2009; Quartaroli, 2009). I used Statistical Package for the Social Sciences (SPSS) software for data analysis.

Theoretical Framework for the Study

History and tradition have shown that parents have the fundamental right to be the best caretakers for their children, and society presumes that parents will act in their children's best interest (Child Abuse and Neglect User Manual Series, 2003). Legal authorities and mandates are in place to address concerns when parents fail to provide the basic needs of or protection for their children. Goldman, Salus, Wolcott, and Kennedy (2003) explained that the basic philosophy of child protective services is to assure that a child grows up in a safe and permanent place with their family. Goldman et al. (2003)

added that laws across states also require that child welfare agencies make reasonable efforts to preserve or reunify families and achieve permanent placements for children. The Child Information Gateway (2012b) noted that statutes in most states use a broad definition of what constitutes reasonable efforts, including accessibility, availability, and culturally appropriate services to increase the capacity of families. The connections between the parents protecting their children and child welfare agencies making reasonable efforts to preserve or unify families prompted my need to examine two theories for this study: a theory of change and social ecological theory.

According to Goldman et al. (2003), a foundational practice manual, in place since the late 1970s, provided a framework for front line-staff and other child welfare and professionals to use as a process to coordinate responses for addressing child abuse and neglect. These coordinated responses provide a framework to address safety, permanency, and child and family well-being as this is the philosophical tenant for child protective services. Both Hernandez and Hodges's (2006) theory of change and Stokols's (1996) social ecological theory comprised the theoretical framework to address child abuse and neglect for this study.

Hernandez and Hodges (2006) defined the theory of change as a facilitating mechanism for linking the planning of collaborative services to improve the community perspective of services. This theory delineates the pathway of an initiative from initiation through the action strategies for measuring the desired outcomes (Hernandez & Hodges, 2006). Research by Taplin, Clark, Collins, and Colby (2013) reported on similar results, noting that the theory of change has emerged as a new way to create and analyze theories for social and political change as well as to test hypotheses and assumptions about what actions would best bring about an intended outcome. For this study, Taplin's et al. (2013) theory of change approach established logical connections to evaluate the commonwealth of Pennsylvania standards used to authorize the licensed foster care placement agencies, evidence based indicators in use, and strategies intended to achieve those results. Meaning that the theory of change supports the retrospective, nonexperimental, methodology to analyze and describe the current commonwealth of Pennsylvania standards. The results of this study can offer the commonwealth of Pennsylvania and foster care agencies a roadmap to determine if standards are outdated and whether national and state measures to increase permanent home placements for children with diagnosed disabilities are needed to achieve the intended results.

While the theory of change is commonly used to evaluate existing programs or plan new initiatives, Taplin et al. (2013) identified a middle ground that programs in operation for years should consider to better understand and determine needed changes; in such cases, organizations should revisit their long-term goals, challenges, assumptions of what is needed, and how best to achieve those goals. Taplin's et al. theory of change offered three basic methods to determine needed changes: "evaluation, conceptualizing and planning initiatives, revisiting goals, assumptions, and activities of an existing initiative (especially if things seem to be not going as well as hoped)" (p. 9).   For this study, the process for creating a theory of change would require the state of Pennsylvania to (a) evaluate the existing provisions used to authorize the licensing of foster care placement agencies, (b) conceptualize evidence-based policies in use and plan collaborative services and strategies intended to achieve results, (c) revisit the goals of the current licensing provisions in place and their expected outcomes, (d) crosswalk perspective for services that offer evidence-based strategies and outcomes from current provisions in use and make assumptions if outcomes are achieved, and (e) determine if activities of the existing provisions used to license foster care placement agencies seem to address a theory of change. Testing the theory of change through a monitoring and evaluation process addressed the RQ and clarified how evidence based strategies are expected to produce particular outputs to improve child welfare outcomes.

Stokols (1996) defined social ecological theory as a set of theories for behavioral changes and environmental factors that are used to improve health. Rotabi (2007) noted that the origin of social ecological theory dates to sociologist Howard W. Odum (1884–1954), who examined the effects of the social and economic welfare of individuals in their environment. The foundation for social ecological theory requires the use of an interdisciplinary approach to design prevention strategies for change with individuals, child welfare systems, communities, and public policies (Stokols, 1996). Stokols's theory supports the research methodology and quantitative design that can be used to propose preventive strategies to improve child welfare outcomes to increase permanent home placement for with diagnosed disabilities.

The major theoretical proposition for this study was that Hernandez and Hodges's (2006) and Stokols's (1996) theories emphasized useful planning strategies to address the needs and desired outcomes for a population. For example, Hernandez and Hodges's (2006) theory provided a local planning perspective to solve problems and identify community-level solutions. This meant that a theory of change suggests a roadmap for policymakers to link national and state standards to achieve desired outcomes. In contrast, Stokols's (1996) theory focused more broadly on the cumulative effect of multiple conditions on the physical, emotional, and social well-being of an individual over a specified time interval. Hernandez and Hodges's and Stokols's theories related to the study approach to help interpret the results of the RQ and inform strategies for ways to improve child welfare practices, so as to achieve and maintain permanent placements for children with diagnosed disabilities who are discharged from foster care.

The Social Security Act of 1980 provided guidelines for states to care for children with special needs who need placement outside their homes or assistance in finding adoptive homes for children (Leslie et al., 2005). In 1994, the Social Security Act was amended to include performance outcomes as the end results for children and families in care (Strickland et al., 2011). Further, Strickland et al. (2011) wrote that the Social Security Act was built on a foundation of federal initiatives for states and federal public health agencies to provide and promote family-centered, community-based, coordinated care for children with special health care needs and their families. These mandates contributed national and state performance standards to guide the delivery of child protection and child welfare services (US DHHS ACYF Children's Bureau, 2014).

In relation to Hernandez and Hodges's (2006) and Stokols's (1996) theories, my theoretical proposition for this study provided a planning perspective that could inform the connections between the population of children to be served, expected results, and evidence-based strategies intended to achieve those results. Consequently, the study results could add to the literature by recommending further studies on the benefits that the theory of change approach and social ecological theory could have with improving the commonwealth of Pennsylvania’s Code that governs the licensing of foster care agencies. Since the 1994 amendments of the Social Security Act, the Children’s Bureau authorized the use of evidence based CFSR for states to help children and family achieve positive outcomes (US DHHS ACYF Children’s Bureau, 2006). These reviews assess the process and progress used by states in meeting the needs of the children being served, especially regarding safety, permanency, and well-being.

Similar to the Children’s Bureau Child and Family Services Reviews, Burris et al.’s (2010) research supported the case for enacting evidence-based laws that improve the public health. However, for these laws to be effective, Burris et al. noted there must be processes to address mediating factors that may deter change. Further, Burris et al. added that laws to improve the health of individuals should be designed to influence the behavior of its intended targets. The laws governing the CFSR were to hold child protective agencies accountable for obtaining outcomes for safety, permanence, and family well-being (US DHHS ACYF Children’s Bureau, 2006). Accordingly, I used a retrospective, nonexperimental, quantitative methodology in this study to assess gaps by describing data that existed between permanent home placements and children with diagnosed disabilities who live in foster care.

The literature I reviewed included studies that were commissioned to improve the quality and safety, permanency, and well-being of children and families being served through Pennsylvania’s foster care system (see Child Welfare Information Gateway, 2008). The implications for positive social change include informing policymakers, foster care and adoption agencies, and families about state and national measures that should be in place to increase the stability of permanent home placements for children with diagnosed disabilities in foster care. Based on these factors, there are concerns about whether the commonwealth of Pennsylvania's Code for child welfare agencies has incorporated strategies for implementing national child welfare outcome measures, as well as concerns about state-specific standards that are part of the state code governing foster child agencies. The literature I discussed throughout this theoretical framework section suggested recommendations for the commonwealth of Pennsylvania's Code to add standards from the *Child Welfare Outcomes Reports to Congress* for state data reporting systems. These recommendations offer critical information to the process of improving federally-mandated outcomes for children and families.

Nature of the Study

In this quantitative study, I used a retrospective design to examine archived data and describe the impact, if any, that the independent variable (diagnosed disabilities) had on the dependent variable (permanent home placements) among Pennsylvania's foster care children who were discharged and were between ages of 0 to 6 years in 2012. According to Belli (2009), a retrospective design looks back in time to collect and assess information without changing the environment, manipulating the data, or randomly assigning the data files. To show the relevant features of the data and to reduce the data to manageable proportions, bivariate analysis testing calculates and presents the data results in tables and diagrams (Belli, 2009; Brown, 2010; Muijs, 2011). Based on

Muijs's (2011) research, I used SPSS software to conduct bivariate analysis techniques to select the study sample, examine the independent and the dependent variables, and described the relationship that exists between them.

The theoretical framework informed the retrospective, nonexperimental, quantitative design and contributes to the understanding of the impact that diagnosed disabilities have on permanent home placements, by connecting existing knowledge and theories in the literature review, along with evidence-based strategies for ways to address the RQ. For instance, obtaining permanency for children in foster care is among the national outcomes established to meet requirements of the Social Security Act (US DHHS ACYF Children Bureau, 2014). The US DHHS ACYF Children Bureau noted that finding permanent homes for children of foster care would require states to monitor the percentage of children who exited foster care (a) to permanent homes such as reunification, adoption, or legal guardianship and (b) were identified as having a diagnosed disability.

The dependent variable of interest for this study was the permanent placements, and the independent variable was diagnosed disabilities. The characteristics that exist among permanent placements (reunification, living with other relatives, adoption, or guardianship for the placement stability of children in foster care) and foster care children with diagnosed disabilities (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions) were collected in this study (see US DHHS ACYF Children's Bureau, 2014). The covariates of interest to complement the dependent variable included (a) Pennsylvania's foster care children, who were served during the FFY 2012 reporting year (October 1, 2011 to September 30, 2012); (b) children between the ages of 0 to 6 years old; (c) female and male children; (d) children of all races; (e) the date the child entered foster care; and (f) the date the child discharged from foster care.

The methodology I used to collect archived data required permission from the NDACAN at Cornell University. Data for this retrospective, nonexperimental, quantitative study included the Adoption and Foster Child Analysis and Reporting System (AFCARS) Data Elements Instrument and the supporting tools provided by the NDACAN. AFCARS encouraged secondary analysis of its archived data elements that were relevant to the study of child abuse and neglect (US DHHS ACYF Children’s Bureau, 2012a). I requested AFCARS data in SPSS format, and service case files were conveniently sampled and analyzed by statistical measures to assess for possible correlations among independent and the dependent variables.

Definitions

Child abuse and neglect: Any cases of harm or neglect to a child that were caused by parents, caregivers, other acquaintances or strangers (US DHHS ACYF Children’s Bureau, 2012a).

Child maltreatment: Children confirmed as victims of child maltreatment have had an incident of abuse or neglect that was verified by an investigation or assessment (US DHHS ACYF Children’s Bureau, 2014).

Diagnosed disabilities: Mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically-diagnosed conditions, as defined by a qualified professional (US DHHS ACYF Children's Bureau, 2014).

Healthy homes: A coordinated approach used to create safer and healthier living environments. Eliminating environmental hazards in homes for asthma triggers and lead paint can significantly reduce the effects on the health of the occupants, particularly children and their families (US DHHS, Office of the Surgeon General, 2009).

Nonprobability sampling: Represents a group of sampling techniques to select units from a population of interest for studying and are of two broad types: accidental and purposive. Purposive sampling, used in this study, is defined as an approach used to sample a problem with a specific plan in mind to identify specific predefined groups (Belli, 2009).

Permanent placement: A planning activity to provide stability for children coming into substitute care with a family to help provide the needed services. The measures about permanent placement include reunification, living with other relatives, adoption, or guardianship for placement stability of children in foster care (AFCARS, 2016; US DHHS ACYF Children's Bureau, 2014).

Substitute care: An out-of-home placement that is sanctioned by the court and directly supervised by an authorized agency or placement in a foster family home or another child caring facility (Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition, 2003).

Assumptions

I assumed that Pennsylvania's foster care agencies had submitted all case level files and that the AFCARS Data Elements Instrument was used to collect the national and state performance requirements for child welfare practice. I also assumed that Pennsylvania's foster care agencies collected all case level files on state outcome measures and national performance objectives and that these could be used to adequately address the RQ. Also, I assumed that the RQ described data on each variable reported and described the effects that the independent variable (diagnosed disabilities) had on the dependent variable (permanent home placements) among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. Finally, I assumed that I could summarize groups of data (i.e., the results of the study) using tables, graphs, and charts to display simple summaries of the sample and the measures.

Scope and Delimitations

The scope of this study encompassed strategies for increased permanent placements of children with diagnosed disabilities who were discharged from foster care in 2012. I chose this specific focus because the Task Force on Health Care for Children in Foster Care (2005) stated that children were more predisposed to persistent health conditions and needed more intensive pediatric service than the general population of children in the United States. Paxson and Haskins (2009) noted similar concerns from research that investigated child maltreatment. Their findings showed that each year, thousands of children are identified by state agencies as having been abused or neglected, and most often by one of their parents. Paxson and Haskins found that those maltreated children who come to the attention of the child protection system experience profound adverse effects on their health and development. These researchers added that these adverse effects could lead to permanent physical and mental impairments later in life such as depression, posttraumatic stress disorder, substance abuse, poor physical health, and criminal activity.

The Child Welfare Information Gateway (2012b) encouraged child welfare agencies to apply laws when making reasonable efforts to remedy the conditions that keep children in the foster care system. The state laws that support reasonable efforts should include securing a legally permanent residence for children in foster care and finding a nurturing family for every child in out-of-home care through family reunification, adoption, guardianship, and permanent placements with relatives (AFCARS, 2016; Child Welfare Information Gateway, 2012b). Earlier investigations noted that child welfare agencies focused primarily on abuse and neglect of children who were placed in substitute care and less often on permanent placements and health factors such as diagnosed disabilities (Child Welfare Information Gateway, 2012b).

The delimitation for the population identified in this study included Pennsylvania's AFCARS data files of both male and female children from 0 to 6 years old, as evidence shows, this age group is more vulnerable to adverse health related factors (see Federal Interagency Forum on Child and Family Statistics, 2012; Task Force on Health Care for Children in Foster Care, 2005). According to the Task Force on Health Care for Children in Foster Care (2005), the adverse-health-related factors are those that require a diagnosis and treatment of conditions such as mental health and developmental conditions. The Federal Interagency Forum on Child and Family Statistics (2012) recognized that having adequate health insurance and access to health care are important factors in obtaining better health outcomes.

A report from the Federal Interagency Forum on Child and Family Statistics (2012) noted that children’s physical health is influenced by their biology, social and physical environment, behavior, and the availability of services. The interagency forum also noted other equally important factors influencing health and encouraged a need to address prevention, treatment, management of illness, and promoting emotional, behavioral, and physical well-being as 10.1 per 1,000 children aged 0 to 17 years had a substantiated report of child maltreatment. The interagency forum contains federal statistics and is a framework that can be used to describe archived data for possible factors that were of interest to me in this study. To address these factors, a quantitative approach was appropriate to gather and assess information from the historical foster care records to determine the extent to which patterns existed between the variables.

As I stated previously, the theory of change and social ecological theory comprised the framework most related to the area of this study and can be used to interface as a roadmap to inform ways that evidence based strategies can increase permanent placements for children with diagnosed with disabilities and who are in foster care. According to Gravetter and Forzano (2012), little attempt has been made to control threats to internal validity in nonexperimental studies, as past studies have been used simply to answer questions about groups or about whether group differences exist. The

US DHHS ACYF Children’s Bureau (2013) reported that the quantitative measures for their study provided reliability and validity from the data collection instrument and that consistent values were confirmed with repeated measurements. Thus, no possible conclusion or potential generalizability can be drawn from the findings of this nonexperimental study. As a result, the findings obtained from this study can be used to display consistency and reliability of the results each time the measures were assessed using the same population sample. The US DHHS ACYF Children’s Bureau seemed to support the use of adoption and foster care data for this study as the data demonstrated reliability and reputability through repeated national use and publications of 23 annual reports.

Limitations

Pennsylvania’s child welfare statistics estimated that a population size of 14,862 children received services through the foster care system and that 8,817 exits occurred during the FFY 2012 yearend report, from October 1, 2011, to September 30, 2012 (US DHHS ACYF Children’s Bureau, 2014). However, this study may be constrained by the chosen study design because I chose the population of interest from a single point in time with a snapshot of conditions present in that instance. The target population of children with diagnosed disabilities who were discharged from foster care into a permanent residence was 1,535 (US DHHS ACYF Children’s Bureau, 2014). To determine the sample size data, only children between the ages of 0 to 6 years from the target population were assessed for this study. Although states are responsible for compliance with federal requirements, there may have been constraints and biases due to differences in the operation and delivery of child welfare services (Child Welfare Information Gateway, 2012b).

There are no reasonable measures to address limitations in this nonexperimental study as the collection and sampling techniques I used to quantify the AFCARS database were to describe the relationship that exists between archived data for diagnosed disabilities (the independent variable) and permanent home placements (the dependent variable). The study variables were not intended for manipulation, random assignment, or understanding significant relationships but rather were intended to describe the conditions of a population of interest at a single point in time. The federal Children's Bureau took steps to assure the accuracy and reliability of the foster care and adoption data around the data quantity to effectively extract and translate into easily quantifiable charts and graphs for this study.

Significance

There are potential contributions of the study to advance knowledge in the discipline about the importance of increasing the stability of permanent home placements for children with diagnosed disabilities and who are being discharged from foster care. Vandivere and Malm (2015) presented findings from eight experimental studies on the positive effects of emotional and legal permanency. Their findings added support for this study, as Vandivere and Malm indicated that obtaining permanency would require that case plan goals include placement stability for foster care children.

Building on the evidence to increase permanent home placements for the general population of children in foster care, findings from this study could be used to support policies for permanent placements for children with disabilities who are in foster care. The concept of permanency in the U.S. child welfare system was based on values provided by families, especially biological families, as well as the importance of attachment between the parent and child (Goldman et al., 2003). The evidence to increase permanent home placements has been in place for several decades; however, Goldman et al. wrote that prevention strategies from professional and community groups are needed to deter complex concerns of child abuse and neglect. Research introduced throughout this chapter cited frameworks for understanding child well-being, identifying factors to reduce child abuse and neglect, and offering strategies for creating lasting change in how communities support families (see Child Welfare Information Gateway, 2013b; Hernandez & Hodges, 2006; Stokols, 1996; US DHHS ACYF Children's Bureau, 2012c, 2014).

The Pennsylvania Department of Public Welfare's vision is to see that its citizens live safe, healthy, and independent lives (Commonwealth of Pennsylvania Code, 1982). To achieve this vision, the National Governors Association Center for Best Practices (2010) reported that Pennsylvania has set a goal to safely reduce the number of children in foster care by 15% to 20% by January 1, 2012. Remarkably, the number of children in out-of-home care was safely reduced to 13% between November 2008 and December 2009 (see National Governors Association Center for Best Practices, 2010). By focusing on evidentiary data from AFCARS Data Elements, in this study I addressed the National Governors Association Center for Best Practices' (2010) and Freundlich's (2010) legislative strategies to safely reduce the number of children in foster care and increase the need for permanent placements when discharging children with diagnosed disabilities from foster care. The hypothesis for this study holds true as the outcomes addressed the variable of interest to increased permanent placements for children in foster care with a diagnosed disability. The findings from this nonexperimental quantitative study found 23,523 children were served in FFY 2012, 3,168 (13.5%) represented only the children who were between ages 0 to 6 and were discharged to permanent home placements. This result adds knowledge to the existing body of literature on the child welfare system regarding strengthening families and improving permanent placements for foster care children with diagnosed disabilities who are in foster care.

According to the Child Welfare Information Gateway (2013a), there are many long-term consequences of child abuse and neglect. Most often, physical injuries may or may not be immediately visible; however, those being reported as having the most pronounced consequences are from physical, psychological, behavioral, and societal injuries (see Child Welfare Information Gateway, 2013). For example, psychological consequences of trauma reported during infancy include difficulty forming attachments to new caregivers (Child Welfare Information Gateway, 2013a). To better understand the long-term effects and ways to address trauma, the Child Welfare Information Gateway used resiliency techniques to address trauma from child abuse and neglect. The use of resiliency techniques is an approach that is now being used in the child welfare system to address past trauma by reducing those consequences or by helping individuals to cope (Child Welfare Information Gateway, 2013a). The Child Welfare Information Gateway noted that resiliency techniques are aimed at providing families with the ability to respond positively to adverse situations and to emerge from the situation feeling strengthened, more resourceful, and more confident.

Another potential contribution of this study that may advance knowledge in this discipline is the fact that federal laws and regulations require states to collect case-level information on all children for whom the state child welfare agency has responsibility for providing care (AFCARS, 2012; Child Welfare Information Gateway, 2013a; US DHHS ACYF Children's Bureau, 2014). The AFCARS Data Elements is the tool used by states to collect information on foster and adoptive parents (AFCARS, 2012). In turn, the ACYF uses the information collected to respond to congressional mandates on state performance on key child welfare outcomes and changes in performance outcomes over time in delivering child welfare services (AFCARS, 2012; Child Welfare Information Gateway, 2013a; US DHHS ACYF Children's Bureau, 2014).

The services provided to children and their families are intended to prevent future instances of child maltreatment as well as remedy conditions that brought children and their family to the attention of child welfare agency. My aim for a positive social change is to provide leadership and advocacy for health equity, services, and interventions that improves birth outcome and family well-being. In addition to this goal, my social change mission is to become a recognized leader and advocate for reducing infant mortality and perinatal disparities in maternal and child health programs and services.

Summary

The Task Force on Health Care for Children in Foster Care (2005) recommended care coordination to promote quality healthcare for children. The findings from research and reports that I cited throughout this chapter have affirmed that children in foster care need to achieve increased permanent placements, especially those with diagnosed disabilities who were being discharged from foster care. The findings also affirmed that foster care systems across the United States are intended to provide a safe temporary placement for children who could not remain safe in their homes. Foster care systems also have their responsibility to address the state's level of compliance with the national standards on child safety, permanent placements, and well-being that may cause unfavorable conditions as well as promote a vision for change (Child Welfare Information Gateway, 2012a, 2012b, 2013a, 2013b; US DHHS ACYF Children's Bureau, 2010b, 2013, 2014).

Despite the many policy reforms to improve permanent placement outcomes for children in the foster care system, health consequences such as having diagnosed disabilities have a delayed effect on the timely discharge of children from the foster care systems (see US DHHS ACYF Children's Bureau, 2010b, 2013, 2014). In this study, I focused on data on Pennsylvania's foster care children to address similar concerns relative to factors associated with children who are being discharged from foster care. I analyzed and described data for trends and patterns that may respond to the timeliness the Pennsylvania's substitute care agencies use in discharging children from the foster care system.

In the following literature review chapter, I will provide research based practices and theories that highlight the use of social ecological theory and theory of change to improve Pennsylvania's compliance with national child welfare standards. In Chapter 2, I will present a review of the work of theorists who have addressed consequences that are related child abuse and neglect as well as offer best practice strategies to improve permanent placements among children exiting foster care with diagnosed disabilities within Pennsylvania’s foster care system. In addition, I will identify those gaps and solutions from the literature on current knowledge trends within child welfare practices and ways to improve permanent home placements for children in foster care. The research I will introduce in the following chapter have social change implications on the health of Pennsylvania’s foster care children and provides evidence to support policies to improve child welfare measures on permanent placements within Pennsylvania’s licensing code.

Chapter 2: Literature Review

Introduction

The research problem in this study was that no evidence had been identified to suggest that Pennsylvania’s licensing code policies governing foster family care agencies had initiatives in place to increase permanent home placement for children with diagnosed disabilities who are discharged from foster care (see Commonwealth of Pennsylvania Code, 1982). Having an understanding of the factors contributing to the problem may inform ways that the Pennsylvania’s licensing code policies could use evidence to increase permanent placements for children with diagnosed disabilities who are in foster care. Stalker and McArthur (2012) reviewed research literature from 1996 to 2009 about child abuse, child protection, and disabled children. Their review noted a strong association between disabilities and child maltreatment, and they suggested that disabled children had been significantly more likely to have experienced abuse than their nondisabled peers. The Task Force on Health Care for Children in Foster Care (2005) added concerns as well by stating that children in foster care were more predisposed to persistent health conditions than the general population of children in the United States.

The purpose of this study was to determine whether standards established for Pennsylvania in 1982 identified evidence of whether state licensing code policies were able to determine the relationships that diagnosed disabilities have on and permanent placements. To address this concern, I used a retrospective, nonexperimental quantitative design. The results of this study provide a more informed understanding of the policies and policy change processes that are needed within Pennsylvania’s licensing codes to increase permanent home placements for children with diagnosed disabilities. According to the US DHHS ACYF Children's Bureau (2014), permanent home placement (the dependent variable) is reunification, living with other relatives, adoption, or guardianship, while diagnosed disabilities (the independent variable) are mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions.

Also included in this chapter will be discussions of trauma-informed services in child welfare, disabilities and permanent placement disruption, the use of a conceptual framework, as well as methodology in a nonexperimental study. In this literature review, I will highlight empirical evidence that addressed approaches to prevent child abuse and neglect and that supports policies and programs related to increased permanent placements in foster care. The empirical evidence provided standards that could be used to improve the licensing of Pennsylvania's code, and regulations governing foster family care agencies statewide. Information from this review will provide a more informed understanding of the policy change processes that could improve the health of children in substitute care and increase permanent placements at discharge. The chapter will conclude with a summary of the gaps in the literature and where I will recommend measures that may improve outcomes for Pennsylvania's children with diagnosed disabilities who are being discharged from foster care services.

Literature Search Strategy

To retrieve literature for this study, I used the following databases: Academic Search Premier, EBSCO, Education Research Complete, ERIC, Health Source, Medline, ProQuest, Pub Med, Sage Publications as well as the Google Scholar search engine. Other sources I gathered information from included relevant agencies and program websites, such as the Pennsylvania Department of Human Service, Philadelphia Department of Public Health, and the US DHHS ACYF Children's Bureau. Finally, information was also retrieved from libraries of local universities as relevant peer reviewed resources were needed to strengthen the reliability and validity of this research. I used the following key search terms and combinations of search terms: abuse and neglect, diagnosed disabilities, foster care children, foster care legislation, life course theory, permanent placements, and trauma-informed care. The scope of literature review covered a timeframe of 11 years.

I found seminal as well as current peer reviewed literature on evidence based practices to protect children and families in foster care. The literature identified the process of increasing permanent placements, the effect of public health laws on improving children's health, the integration of public health laws to reduce child abuse and neglect, and the effects of national, state, and local prevention policies. I also reviewed the theoretical framework and the methodologies of previous nonexperimental studies.

Throughout the literature review for this study, I initiated best practice results from other studies and reports that have been effective in addressing similar issues in the past and that could be applied to this study. In addition to referencing earlier landmark studies, I focused on research published in the last 5 years to bring readers up-to-date with current literature on the topic as well as to provide a possible justification for future research in the area. The types of literature and sources searched were peer reviewed and nonpeer reviewed. They were organized to include local, state, and national policies for foster care children from 0 to 6 years of age that offered ways to increase permanent placements at discharge and eliminate barriers at exit due to a diagnosed disability. The seminal literature influencing this study included Belli (2009); Child Welfare Information Gateway (2012a, 2012b, 2012c, 2012d); Commonwealth of Pennsylvania Code (1982); Task Force on Health Care for Children in Foster Care (2005); and US DHHS ACYF Children's Bureau, (2014), while current peer reviewed sources in this review included theorists, such as Bethell et al. (2011); Jaudes et al. (2012); Powers, et al. (2012); Rotabi (2007); Sege (2010); and Stokols (1996). While I did not identify any current research as being specific to this study topic, correspondence from the US DHHS ACYF Children's Bureau, Region III (2009) regarding Pennsylvania's Department of Human Services Child and Family Services Plan for FFYs 2010 to 2014 supports an integration with its Child and Family Services Review Program Improvement Plan to better achieve safety, permanency, and well-being for its children and families. The approach taken is committed to strengths based practices that are focused on continuous quality improvement to meet national and state outcomes- based indicators (US DHHS ACYF Children's Bureau, Region III, 2009).

Theoretical Framework

The Goldman et al. (2003) reinforced that every child has the right to adequate care and supervision and the right to be free from abuse, neglect, and exploitation. Furthermore, Goldman et al. noted that interventions for child protective services become necessary when parents request assistance or fail by their acts or omissions to ensure that the physical, mental, emotional, educational, and medical needs of their children are adequately met. The basic philosophical tenets for child protective services are built on five main perspectives to promote systems of change that are ecological, strengths based, developmental, permanency planning, and cultural competence perspective.

I anticipated that addressing the problem statement in this study would contribute an understanding of what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania’s foster care children who were discharged and were between the ages of 0 to 6 years in 2012. Taplin et al. (2013) stated that the theory of change originated as an evaluation tool to measure indicators of success among social and political programs. I used Hernandez and Hodges’s (2006) theory of change approach to link the planning and implementation of services to improve permanent placements for children with diagnosed disabilities who are being discharged from foster care. Through the years, Goldman et al. (2003) served as a valuable resource for building knowledge, promoting effective practices, and enhancing community collaboration and seems to have provided a framework for Pennsylvania’s child protective services.

In Chapter 1, I noted that states have a national mandate to address child welfare measures to reduce the prevalence of child abuse and neglect; the social ecological theory offers strategies to prevent child maltreatment (Stokols, 1996; US DHHS ACYF Children’s Bureau, 2014). A report from the National Technical Assistance and Evaluation Center for Systems of Care (2008) pointed out that the use of individualized strengths based approach strategies within the child welfare practice offers ways to increase the safety of and permanent placements for children. This means that the strategies used to increase permanency for children with diagnosed disabilities should engage families as a partner in the planning of services that are evidence based and tailored to build upon needs and strengths of families. Given these facts, I chose the theory of change and social ecological theory as the theoretical framework for this study because they support the work of policymakers and stakeholders within the child welfare system to include ways that can increase permanent placements for children with diagnosed disabilities who are in foster care.

According to Rotabi (2007), the origin of social ecological theory examined the effects of social and economic welfare of individuals in their environment. For children in foster care, conflicts with one child or another family member can adversely affect others in the immediate surroundings. Therefore, my use of the social ecological theory for examining and recommending improvements to Pennsylvania's child welfare system could add to the use of prevention strategies to describe the support that is needed for children, caregivers, community, and society (see Child Abuse and Neglect User Manual Series, 2003; Stokols, 1996). Samuelson's (2010) research built upon existing theory that supports the use of an ecological approach to capture the multiple influences that affect both child and family such as community, school, extended family, and other social factors. Samuelson's approach also tied in with the theory of change in addressing my RQ to target a specific age and variables to best meet the needs of the children in foster care as well as their caregivers or families.

Seminal researchers on child welfare practice across the United States influenced the major federal laws that guided the theoretical framework for child protection, child welfare, and adoption to make it possible for children to grow up in permanent homes of safe and caring families. The laws were used to provide specific mandates, principles, and rules for states to deliver effective child welfare services (Child Welfare Information Gateway, 2012a). As indicated by the Child Welfare Information Gateway (2012a), there were several laws that focused on child protection, child welfare, and adoption, beginning with the passage of the CAPTA in 1974. The Child Welfare Information Gateway noted that the CAPTA law provided financial assistance for the prevention, identification, and treatment of child abuse and neglect. More recently, the passage of the Child and Family Services Improvement and Innovation Act of 2011 required states' welfare standards to have oversight and coordination of health care services for foster care children who are being treated for emotional trauma and receiving psychotropic medications (Child Welfare Information Gateway, 2012a). The Child Welfare Information Gateway added that a major provision of this act was for states' child welfare plans to "describe activities to reduce the length of time children under age 5 are without a permanent family" and to identify those within that population who were at the "greatest risk of maltreatment" (p. 4).

The rationale for the choice of theories for this study was guided by major child welfare outcome measures to improve the safety, permanent placements, and well-being of foster children. The selected theories relate to this study in several ways. For example, Goldman et al. (2003) provided a manual for child protective services workers and other professionals to use in instances to address child protective services. Additionally, US DHHS ACYF Children’s Bureau (2014) reported that the outcome measures were needed to (a) reduce the recurrence of child abuse and neglect, (b) reduce the incidence of child abuse and/or neglect, (c) increase permanent placements for children, (d) reduce time in foster care to reunification without increasing reentry, (e) reduce time in foster care to adoption, (f) increase placement stability, and (g) reduce placements of young children in group homes or institutions. Separate from national outcome measures, states were also responsible for collecting individual measures as a part of the CFSR (US DHHS ACYF Children’s Bureau, 2014). These CFSR were to measure the timeliness and permanency of reunification, timeliness of adoptions, permanent placements for children in foster care for long periods of time, and placement stability while in foster care.

The US DHHS ACYF Children’s Bureau (2014) noted that the NCANDS collected and analyzed state data annually that pertain to children who are reported to child protective services agencies as alleged victims of abuse or neglect. These state data files hold detailed case information about children who are subjects of investigations or assessments in response to maltreatment allegations. Freundlich (2010) outlined several legislations in place to help reduce the population of children in foster care and ensure that children have the permanent families to oversee their care. Freundlich added that states must comply with these legislations to be eligible for federal funding under certain programs. According to Freundlich these legislations provide a framework to (a) support community based efforts and conduct initiatives aimed at preventing child abuse and neglect; (b) support networks of coordinated resources, as well as activities to better strengthen and support families to reduce the likelihood of child abuse and neglect; and (c) foster understanding, appreciation, and knowledge of diverse populations to effectively prevent and treat child abuse and neglect. The framework that guided these legislations can provide this study with ways to explore key elements that articulate principles for good practice. These legislations noted by Freundlich can offer recommendations for Pennsylvania's code to govern the licensing of foster care agencies and address permanent placements among children with disabilities who are in foster care and who are also at greater risk for child maltreatment than children without disabilities. The studies related to the constructs of interest and chosen methodology from the literature provide the rationale for the selection of the variables for this study.

Literature Review Related to Key Variables and/or Concepts

According to the US DHHS ACYF Children's Bureau (2014), when children are placed in foster care, state child welfare agencies have the responsibility to ensure that these children are in stable placement settings that are age-appropriate to meet their service needs. The Children's Bureau research on child welfare issues has led to a series of Child Welfare Outcomes Reports for the U.S. Congress since 2008. The national *Child Welfare Outcomes 2009-2012 Report* to Congress indicated that approximately 397,000 children in foster care on the last day of the 2012 federal fiscal year. An estimated number of 241,000 children were discharged from foster care during the same period (US DHHS ACYF Children's Bureau, 2014).

The constructs of interest for this study were selected from the national performance outcomes to increase permanent placements for children in foster care and the state outcome measures are for children with diagnosed disabilities who were discharged from foster care during the 2012 reporting year. The aim of this literature review is to identify studies that utilized or employed the identified variables and proposed methods to validate the need to describe historical records from Pennsylvania's 2012 outcomes data for trends and other characteristics that are identified within these constructs. There were no current studies identified that used the Commonwealth of Pennsylvania's Code to address the variables for this study. A review of research promoting early identification of and intervention in disabilities for foster care children found that children and adolescents in the foster care across the United States experience poorer health and often have unmet health care needs including undiagnosed or under-treated medical conditions (Stalker & McArthur, 2012; Task Force on Health Care for Children in Foster Care, 2005).

In a longitudinal, randomized study that examined the effects of self-determination enhancement on the transition outcomes of youth in foster care and special education, Powers' et al. (2012) research also noted that very little research has been conducted on the outcomes of young people in foster care with diagnosed disabilities in foster care. Nevertheless, this study acknowledges that the 2008 Fostering Connections Act required that youth preparing to exit foster care should have a written transition plan that describes the needed programs and services for enhanced self-determination. Powers' et al. study investigated the outcomes of exposure to a *Take Charge* model to determine the extent to which youth who participated in enhancement activities exhibited increased self-determination. Sixty-nine youths were enrolled over three studies and were randomly assigned to either a treatment or comparison group; youths were assessed at baseline, post-intervention, and at one-year follow-up (Powers et al., 2012). Powers' et al. research revealed evidence of the efficacy within the *Take Charge* model used in the intervention group to increase self-determination. Coaching and mentoring had positive effects on youths over time by enhancing their quality of life goals.

Evidence Based Practices to Protect Foster Care Children

Researchers in the discipline have approached the problem of child safety in many ways. For instance, the passage of the Fostering Connections to Success and Increasing Adoptions Act (Public Law [P.L] 110-351) in 2008 expanded adoption and health care incentives (Child Welfare Information Gateway, 2012a). These incentives provided guardianship assistance payments for children in foster care and adoption through age 21. Provisions of this act came into effect on October 1, 2010, to allow states to provide incentives to youths who were in “school, employed, engaged in another activity designed to remove barriers to employment, or who were incapable of doing so due to a documented medical condition” (Child Welfare Information Gateway, 2012a, p. 8).

The Child Welfare Information Gateway (2012a) acknowledges that an inherent weakness to this approach is that current case plans should ensure the educational stability of youths in foster care without consideration to the extent of medical conditions. Jaudes, Champagne, Harden, Masterson, and Bilaver (2012) wrote that with the passage of the Fostering Connections Act, the federal government placed health care for children in foster care as a top priority. This priority led to the expansion of a medical home model to address key problems preventing good health care for children. Nevertheless, Jaudes et al. noted that this approach has an inherent weakness as state plans addressed salient and characteristic issues such as (a) sufficient funding, (b) improved collection of health histories, and (c) improved coordinated care of the health care system.

Rationale for Selection of Variables

According to the US DHHS ACYF Children's Bureau (2014), while foster care may be necessary to ensure a child's safety and well-being on a temporary basis, permanent placement is one of the primary national outcomes of foster care, and is the concept underlying the dependent variable of interest for this study. The rationale for selecting this variable is supported by the US DHHS ACYF Children's Bureau, which reported that outcomes such as reduced incidence and recurrence of child abuse and neglect, as well as reduced time in foster care to reunification was interconnected to permanent placement plans for children in foster care. Permanent placement refers to children being discharged from foster care and being reunified with biological parents, or adopted, placed in relative custody, or placed legal guardianship care (US DHHS ACYF Children's Bureau, 2014).

The *Bulletin for Professionals* from the Child Welfare Gateway (2012d) identified reunification and prevention of reentry as the preferred options to achieve permanent placements. Yet, child welfare agencies have endured many challenges in obtaining reunification that is timely and does not result in reentry or recurrence of child abuse and neglect. The *Bulletin for Professionals* from the Child Welfare Gateway noted that among the benefits were the maintenance of stable homes to promote consistent family relationships and social well-being, permanent placements and safety, cost benefits to states and local agencies having fewer children in care, and the receipt of stable federal funding (Child Welfare Gateway, 2012d). These strategies from the Child Welfare Bulletin serves as a significant benefit for the Pennsylvania's code that governs the licensing of foster care agencies to consider, as this may prevent the reentry of children back into foster care.

Fang, Brown, Florence, and Mercy (2012) examined child welfare services to assess the estimated costs associated with servicing child maltreatment victims for at least a year. These researchers used archived data to develop the average lifetime costs per incidence of child maltreatment. To estimate the medical costs of maltreatment during childhood, Fang et al. linked surveys and Medicaid claims from a sample of 1,151 children with cases that were investigated by child protective services. Fang et al. noted that the Administration for Children and Families also used similar methodology from other researchers to estimate the lifetime costs of disease when other costs were not available. By using Medicaid data collected about children as a comparison group, Fang et al. assessed the difference of annual medical costs for the case and control groups as being $2,703 (2003-dollar value) and $3,184 (2010-dollar value) for the medical costs of nonfatal child maltreatment. The costs of the true burden of child maltreatment did not include fatalities, or the type and severity of maltreatment. Fang et al. emphasized that given the substantial economic burden of child maltreatment, the benefits of evidence based and prevention strategies would likely outweigh the costs for effective programs.

The National Council of Juvenile and Family Court Judges (2013) reported that the National Governors Association Center for Best Practices (2010) conducted studies, and determined that African-American and Native American children enter the foster care system at rates higher than those of the general child population. The National Council of Juvenile and Family Court Judges examined AFCARS FFY 2011 data relevant to child welfare. The results found that children from racial and ethnic non-White groups were represented disproportionately in the child welfare when data of children entering care, discharged from care, and remaining in care at the end of the 2012 year were compared to children of other ethnic groups. Consequently, the case files utilized as the data source were examined for possible disproportionate rates for Pennsylvania's foster care children. A bulletin from the National Council of Juvenile and Family Court Judges showed those African American children were disproportionately represented in the United States foster care system. Evidence from this national bulletin showed that the rates of African American and Native American children in foster care were higher than in the general population of foster care children in most states.

The Adoption and Safe Families Act of 1997 (P.L. 105-89) also required child welfare agencies to submit race data on children in foster care to the AFCARS (National Council of Juvenile and Family Court Judges, 2013). The report of the National Council of Juvenile and Family Court Judges (2013) showed:

> Disproportionality is the level at which groups of children are present in the child welfare system at higher or lower percentages or rates than in the general population. An index of 1.0 reflects no disproportionality. An index of greater

> than 1.0 reflects overrepresentation. An index of less than 1.0 reflects underrepresentation. (p. 1)

This report from the National Council of Juvenile and Family Court Judges (2013) used the 2011 estimates from AFCARS and census data to calculate the current index for all states. Comparisons made in the national report on disproportionate rates by states for African American children showed that the most overrepresented rates were seen in Utah, Wisconsin, and Wyoming. The next highest rates were seen in California, Colorado, Idaho, Illinois, Iowa, Nebraska, and Pennsylvania. The National Council of Juvenile and Family Court Judges made further comparisons between Pennsylvania's 2000 and 2011 rate to assess the proportion of ethnic or racial groups of children in the child welfare system compared to those groups in the state population. The results showed that African American children in Pennsylvania had an overrepresentation rate of 4.1 in 2000, which had fallen to 3.4 by 2011 within the child welfare population (National Council of Juvenile and Family Court Judge, 2013).

Shown on the AFCARS Data Elements Instrument Tool, the elements of interest for this study were child's state, birth date, age (between 0 to 6 years when served in 2012), gender, race and clinical diagnosis as having at least one disability (AFCARS, 2013). The AFCARS tool also contains date of entry into foster care, date of discharge, and discharge status (adoption, guardianship, parents or caregivers, and other reasons not documented in the records) to answer the RQ (AFCARS, 2013). Child Welfare Information Gateway (2012b) reported that federal mandates encourage states and territories to make reasonable efforts to preserve and reunify families. However, the statutes in most states are defined quite broadly on what constitutes reasonable efforts. The Child Welfare Information Gateway indicated that a consensus was for states to show efforts of accessibility, availability, and cultural appropriateness of services that are designed to improve safe and stable homes for families. There is a significant gap in the current research literature as what constitutes reasonable effort is broadly defined and interpreted by states, and as case plans toward obtaining the goal of permanent placements may vary (Child Welfare Information Gateway, 2012b).

The absence of a permanent placement plan may affect the functionality of the AFCARS Data Elements Instrument standards that are meant to provide a structure for foster family care agencies to screen children for diagnosed disabilities. Children with diagnosed disabilities are those whom a qualified professional has clinically diagnosed as having mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions (US DHHS ACYF Children's Bureau, 2014). This is regardless of whether the diagnosed disabilities are among the factors that led to the children's removal from their places of residence. Diagnosed disabilities were among states' outcome measures tracked for children who were discharged from foster care during the 2012 fiscal year to reunification, adoption, legal guardianship or other relative (US DHHS ACYF Children's Bureau, 2014).

A rationale for the selection of the clinically diagnosed disability variable is that the AFCARS Data Elements include information to assess if children in foster care have diagnosed disabilities. Further, the AFCARS data are used to determine if states' level of compliance were in line with the national standards on child safety, permanent placements, and well-being such as the risk of future maltreatment and parental protective capacity (US DHHS ACYF Children's Bureau, 2012a). Along with these standards, the AFCARS Assessment Review process provides technical assistance to states to ensure the accuracy and reliability of the foster care and adoption data. In conjunction with states conducting their own annual AFCARS Assessment Review, a national Statewide Automated Child Welfare Information System is used to assess the efficiency and effectiveness of states' data collection, extraction, and reporting processes for obtaining national outcome measures (US DHHS ACYF Children's Bureau, 2012a). States' whose child welfare service data fail to meet national outcome measures or associated factors assessed in the CFSR are required to submit Program Improvement Plans to meet those compliance factors (US DHHS ACYF Children's Bureau, 2012a).

The AFCARS (2012) noted that data elements were used to assess whether foster care children had been clinically diagnosed with a mental, physical, emotional, or other medically diagnosed conditions. However, the national report identified instances of underreporting of diagnosed disabilities, making it a challenge for the AFCARS to accurately assess states' data. For instance, there were cases in which child welfare staff had identified foster children who had been clinically diagnosed with applicable disabilities, but failed to indicate the condition associated with the disability. In cases where no applicable diagnosed condition was selected, the AFCARS Assessment Review process would select a not-yet-determined response to show whether a child had been diagnosed with a disability (AFCARS, 2012).

The Child Welfare Information Gateway (2012d) cited the U.S. Census Bureau's and the U.S. Department of Health and Human Services' data from 2012 that showed nearly 4% of children had disabilities and in the same year, reported cases of child maltreatment of 9.3 per 1,000 children in the population. Amazingly, the Child Welfare Information Gateway reported that:

> States are not required to submit data on the disability status of abused or neglected children, variation in the way States define and collect these data makes it difficult to accurately estimate the rates of maltreatment among children with disabilities. (p. 2)

This added significant challenges for national and state statistics that were used to compile annual child maltreatment report from the Children's Bureau. Howard and Brooks-Gunn (2009) reported that theorists and policymakers feel that home visiting programs could maximize their effect by carefully following program mandated guidelines and using professional staff whose credentials are consistent with program goals. The Child Welfare Information Gateway examined data on roughly 484,000 victims in 42 states that submitted some results on children with disabilities and found that "11 percent of child maltreatment victims had a reported disability" (p. 3). The data examined also revealed that children with disabilities were 1.5 to 10 times more likely to experience abuse or neglect than children without diagnosed disabilities.

Studies Related to the Key Variables

The dependent variable is permanent home placements to reunification with parent or caregiver, living with other relative, adoption, or guardianship; the independent variable is diagnosed disability for foster care children with mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions. Freundlich (2010) wrote that state lawmakers play the critical role of leading efforts that will safely decrease the foster care population. In doing so, consistent strategies are needed to improve foster care prevention, permanent placement planning, and family support for an estimated number of 500,000 children who are in foster care. Consequently, Freundlich suggested some legislative strategies that could safely reduce the population of children in foster care, as well as, ensure that children have the permanent families they need and deserve.

Freundlich's (2010) suggestion drew on the creative work being undertaken by state lawmakers across the country. There are federal laws that provide a framework for legislators to develop policies, strategies, and practices at the state level. The enactment of the Fostering Connections to Success and Increasing Adoptions Act of 2008 provided new opportunities to effectively and safely reduce the number of children in foster care (Freundlich, 2010). Pennsylvania's Code that governs the licensing of foster care agencies could adopt these opportunities as evidence-based and promising practices in child welfare that have been shown to effectively meet the safety, permanent placements, and well-being needs of children and their families.

The framework that state legislators focused on are in three areas (a) preventing out-of-home placement and reentry into foster care, (b) reducing length of stay, and (c) reducing the disproportionate and disparate outcomes for children of color in foster care (Freundlich, 2010; National Council of Juvenile and Family Court Judges, 2013; National

Governors Association Center for Best Practices, 2010). The National Governors Association Center for Best Practices (2010) highlighted the efforts proposed by several states including Pennsylvania to safely reduce the number of children in foster care by 15% to 50% by 2012. Freundlich (2010) added that the state legislative framework to prevent out-of-home placement and reentry into foster care are strategies adopted by evidence based programs such as the Nurse Family Partnership, the Incredible Years, and the Triple P Positive Parenting Program. These evidence based strategies could beneficial for Pennsylvania's Code that governs the licensing of foster care agencies to consider for addressing disproportionate and disparate outcomes.

Fang et al. (2012) added support to the Nurse Family Partnership program as it demonstrated successful outcomes that showed great potential for reducing the economic burden of child maltreatment, especially to prevent out-of-home placement for young children. Supporting families after children who have been discharged from foster care were also seen as an effective strategy to strengthen and support the reunification process and prevent reentry into foster care (Freundlich, 2010). Further, Freundlich (2010) indicated that state legislation's approach to reducing the length of stay in foster care offers support to keeping families together in effort to decrease the amount of time children remained in foster care. Freundlich added that legislative strategies proposed to achieve these improvements include strengthening the courts administering child welfare cases, as well as improving the knowledge and training of legal advocates representing children and families.

Sound planning practices are the key strategy, as they should be designed to focus on permanent placement's goal of reunification, adoption, guardianship, or living permanently with a relative or other planned arrangement (Freundlich, 2010). Freundlich (2010) also noted that legislators from the states of Michigan and Texas were examining the disproportionate representation of African American children and other children of color in their states' child welfare and juvenile justice system, to addressing strategies that will correct those disparities. Several other states' legislative approaches were offered to reduce racial and ethnic disproportion and disparate outcomes for children of color in foster care. Strategies have included strengthening the child welfare workforce, authorizing funds for added services and supports, reinvesting savings from safe reductions in the foster care population into preventive and intervention services, requiring use of performance-based contracts between public and private child welfare agencies, and creating multidisciplinary commissions and oversight or advisory boards (Freundlich, 2010).

Review and Synthesis of Studies Related to the Research Question

Children classified as victims of child maltreatment were often placed in foster care due to abusive or neglectful situations. While this study is not focused on child maltreatment, children who entered the child welfare system were initially classified as victims of child maltreatment (US DHHS ACYF Children's Bureau, 2014). There were approximately 679,000 child maltreatment cases confirmed with incidents of abuse or neglect that were substantiated through investigations or assessments in 2012 (US DHHS ACYF Children's Bureau, 2014). The Children's Bureau reported that Pennsylvania had confirmed services to 14,862 children in foster care. This number was a subset of the child maltreatment cases in 2012. The literature shows that children with diagnosed disabilities who are in foster care have less successful placements than those without (Bethell et al., 2011; Jaudes et al., 2012; Sege, 2010; Task Force on Health Care for Children in Foster Care, 2005; US DHHS ACYF Children's Bureau, 2014). This study describes Pennsylvania's foster care data for children with disabilities, as well as describes whether there were less successful placements for these children in 2012.

My primary intent for conducting this study is to understand the factors that are needed to achieve a permanent home placement for children with diagnosed disabilities in foster care. The RQ looked at what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and who were between the ages of 0 to 6 years in 2012. The research by Bethell et al. (2011) added support to this RQ as it evaluated national and state data on the prevalence of health problems and special health care needs of children across the United States. Bethell et al. assessed health care quality, adequacy and consistency of insurance coverage, access to dental and medical care, preventive and specialized care, medical home, and care coordination by insurance type, special health care needs, and race and ethnicity. Bethell et al. noted that their quantitative research assessed survey results of 91,642 children who are 0 to17 years of age from the 2007 National Survey of Children's Health. Bethell's et al. research revealed that about:

> 43% of US children (32 million) currently have at least 1 of 20 chronic health conditions assessed, ...compared with privately insured children, the prevalence,

> complexity, and severity of health problems were systematically greater for the 29.1% of all children who are publicly insured children.… (p. S22)

Bethell et al. (2011) found through their analysis that while 45% of all children in the United States had adequate insurance, a preventive care visit, and a medical home, children with diagnosed disabilities such as autism and asthma received the minimal quality of care due to gaps in insurance coverage. Outcomes from Bethell’s et al. research emphasized the importance of health care insurance duration and adequacy, health care access, and better management of chronic conditions, as these were among the quality of care goals reflected in the Children’s Health Insurance Program Reauthorization Act of 2009 and the Patient Protection and Affordable Care Act of 2010 (ACA). These findings support recommendations from the Task Force on Health Care for Children in Foster Care (2005) to protect the health of children entering foster care, considering that they were more prone to chronic health conditions.

In a similar effort to promote strategies to improve the health of children, Sege and De Vos’s (2010) work offered a broader framework for clinicians and policymakers to use in evaluating clinical practice. This framework showed that many clinicians had shifted their practice from focusing on disease and infection, to focusing more attention on health promotion and risk reduction strategies (Sege & De Vos, 2010). Citing a randomized controlled trial that focused primarily on care of newborn infants to prevent and treat childhood infections, Sege and De Vos showed evidence-based methods to evaluate the effectiveness of short-term medical treatments. However, the evidence found failed to address changes in childhood morbidity and treatment, as the tools used to gather data and measure the effectiveness of health care interventions did not include current interventions. Sege and De Vos stated that:

> The effects of interventions on children are frequently realized years later. This not only inflates the complexity and cost of research, but also risks rendering a study irrelevant by the time it is completed, as the conditions under study may have changed in the intervening decades. (p. 2).

Sege and De Vos (2010) compared tools that were used to track childhood screening from the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force (USPSTF). The two organizations had different missions: the AAP provide a wide range of guidelines for clinical preventive care, while the USPSTF reviewed published evidence for prevention and health promotion activities for individuals at all ages. Sege and De Vos acknowledged that both tools tracked interventions but failed to keep pace with technological advances that are needed to gather and measure data, as well as to promote timely interventions. Sege and De Vos assessed results from a randomized controlled trial and showed that while improvements were seen in health, there were countless interventions that were still needed to improve children's health that did not always involve medical treatment. The trial results showed that children's behavioral and emotional development resulting from "accidental injury, abuse, drug abuse, obesity, poor housing, and substandard education endanger more children than do infectious diseases" (Sege & De Vos, 2010, p. 2). These results seemed to suggest that health care improvements in pediatric medicine should be informed by evidence based strategies with an “aim to change the physical, social or emotional environment in which children live and learn” (Sege & De Vos, 2010, p. 2).

Sommers and Rosenbaum (2011) indicated that the ACA of 2010 would guarantee more access to affordable health insurance among Medicaid eligible consumers and citizens with a family income that did not exceed 133% of the federal poverty level. Considering that most children in foster care are insured through Medicaid, this provides states’ foster care agencies the opportunity to develop solutions that address the issues of this population. Furthermore, the ACA would serve to integrate many public health laws, and would be an ideal strategy to address health concerns. However, Sommers and Rosenbaum cautioned that as incomes rise and fall, ACA policy may potentially shift recipients’ health benefits back and forth between Medicaid and insurance exchanges. Consequently, states and the federal government were encouraged to adopt strategies to diminish the rate of these recurrences that could potentially transition recipients’ coverage back and forth (Sommers & Rosenbaum, 2011). A similar precaution may require consideration of Pennsylvania’s Medicaid insurance serving children in foster care to assure continuous and year-round health insurance coverage to improve access to care.

Addressing continuity and quality of care would require using the “same plans with the same provider networks” participating in both the exchange and Medicaid markets (Sommers & Rosenbaum, 2011, p. 234). This action may create challenges for families, as ACA allows for the shifting between Medicaid and exchange coverage. Based on the findings from their research, Sommers and Rosenbaum (2011) encouraged child welfare services “to take steps to align, as much as possible, the conditions of participation for both exchange-qualified health plans and Medicaid managed care organizations, to promote dual market participation” (p. 234). Policies and programs promoting educational access, stability, and success for vulnerable children and families adds continuity and quality of care and is a significant benefit for the Pennsylvania’s Code that governs the licensing for foster care agencies.

Provisions of the ACA of 2010 promote comprehensive health insurance reform to hold insurance companies accountable, aid the lowering of health care costs, and guarantee additional health care choices to enhance the quality of care for communities (US DHHS ACYF Children’s Bureau, 2011). This health insurance reform law also authorized the creation of home visiting programs to improve early childhood service coordination and delivery for families in at-risk communities. The results of this health insurance reform law led to the formation of states’ advisory councils to bring federal and other systems together to ensure that children and families receive early care and access to educational programs that promote stability for those entering the child welfare system.

Promising Practices for Increasing Permanent Home Placements

The Commonwealth of Pennsylvania Code establishes the minimum operating guidelines for foster family care agencies to reduce the risk to children in placement by protecting their health and safety. Additional laws and policies have been delineated specific to the prevention of abuse and neglect to foster care children. For example, the US DHHS ACYF Children’s Bureau (2011) cited early childhood education programs that were effective at preventing abuse and neglect among children in foster care. Programs such as Head Start and Early Head Start stated that children in foster care were categorically eligible for services, regardless of family or foster family income. The laws and policies from these programs can serve to enhance Pennsylvania's guidelines for foster family care agencies to provide educational, economic, health, and law enforcement benefits to children and families.

The US DHHS ACYF Children's Bureau (2011) also cited CAPTA program as providing child protective services that link developmental, mental health, early intervention, and health services to evaluate and treat children who have been maltreated. The Fostering Connections to Success and Increasing Adoptions Act of 2008 was also noted for providing child protective services. This act promoted permanent placements for families by allowing relatives to gain guardianship and adoption of children to improve access to education and health care services. This legislation encouraged minimal disruption to early care and education when removing children from their homes or assigning placement and reunification with parents, regardless of when enrollment in foster care took place (US DHHS ACYF Children's Bureau, 2011). Keeping children in primary care and schools of origin was the outcome and ideal choice being promoted (US DHHS ACYF Children's Bureau, 2011).

To assess and ensure the provision of a comprehensive system of services for children with special health care needs, Strickland et al. (2011) conducted and reported on the outcomes of their survey of children with special health care needs. Their report endorsed the need for a public health approach for those "who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required for children generally" (p. 224). Strickland et al. surveyed 40,723 families of children with special health care needs in 2005 and 2006. The results of the survey showed that only 17.7% of these children received services in a high-quality service system based on six quality indicators. Strickland's et al. quality indicator measurements include:

> (1) family partnership in decision-making and satisfaction with care, (2) receipt of care through a medical home, (3) adequate health insurance, (4) early and continuous screening and surveillance, (5) services that are organized for ease of use, and (6) effective transition planning for adult health care. (p. 224)

The report suggested that significant service delivery need to occur to meet national Healthy People objectives for children with special needs. Strickland et al. suggested that a public health infrastructure-building approach would ensure that children identified with special health care needs have access to a comprehensive system of services.

Strickland et al. (2011) noted that the comprehensive approach would increase the odds of more children with special health concerns having access to and receiving a seamless system and higher quality of services. Their research showed that children with special health care needs had medical and functional limitations, and thus required a variety of professionals and supportive services. Moreover, Strickland et al. added that the health care needs of these children are complex and long-term, and that they consume a large share of health care dollars. As a result, the federal bureau overseeing Children with Special Health Care Needs programs work with states and other federal stakeholders to provide direction, monitoring, and policies to protect children with special needs (Strickland et al, 2011.). Strickland's et al. policy approach appears relevant to addressing the commonwealth of Pennsylvania Code statute governing foster care agencies by improving practice standards and promoting uniformity among service agencies working to keep children and families' safe.

The US DHHS ACYF Children's Bureau (2006) wrote that the circumstances declaring families as neglectful do not exist in a vacuum. This means that child protective service (CPS), a division within state and local social service agencies, has jurisdictions by law to conduct initial assessment or investigation of reports of child abuse or neglect. The US DHHS ACYF Children's Bureau reported that the CPS assessments or investigations found that most attention is focused on the conditions in the home associated with parental omissions in care. The US DHHS ACYF Children's Bureau added that there is a lack of consensus in defining whether neglectful acts were associated with an action or inaction that led to neglectful or intentional behaviors. These neglectful actions or inactions affects the caring for a child, impacts the health, safety, and well-being of the child, and led to the failure or inability to provide adequate food, shelter, or clothing, or failed to protection a child from poverty.

As there are several classifications for neglect, the definition used in this dissertation for being neglectful means omitting needed protection to children that improves their well-being (US DHHS ACYF Children's Bureau, 2006). The definition helps determine whether an incident or a pattern of behavior qualifies as neglect, gauge its seriousness or duration, and most importantly, decide whether the child is safe. The

U.S. Department of Health and Human Services Health Resources and Services Administration Maternal and Child Health Bureau (US DHHS HRSA MCHB, 2010) offered new maternal and child health strategies to further improve the health of families. The US DHHS HRSA MCHB proposed the use of a life course theory that is defined as a "conceptual framework that helps explain health and disease patterns particularly health disparities" (p. 2). Rather than focusing on one disease or condition at a time, this strategy encourages a greater focus being given to understanding the underlying factors of persistent inequalities in health for a wide range of diseases and conditions across population groups.

The RQ for this study shares some similarity with the life course theory as it describes data on each variable reported to determine what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. The US DHHS HRSA MCHB (2010) proposed that the use of scientific knowledge and approaches be used to improve health outcomes and decrease disparities across population groups. I recognize the effects that social determinants of health contribute to the state of health from factors that may be biological, behavioral, psychosocial, socioeconomic, or social in nature and that result in health outcomes across the course of a person's life.

The factors of social determinants of health in this dissertation include the following: biological factors relate to male and female foster care children who are 0 to 6 years old; behavioral factors relate to caregivers' practices that may contribute to abuse and neglect; psychosocial factors arise from impediments when children with diagnosed disabilities are being discharged from foster care; socioeconomic factors are present in environments of discrimination or poverty; and social factors relate to having insufficient access to high-quality health care or not having access to adequate health insurance. These results indicate that there is the potential of synergistic effects caused by the combination of social determinants affecting children foster care who are more predisposed to chronic and persistent conditions.

By making child maltreatment prevention a public health priority, Zimmerman and Mercy (2010) wrote of a better-start approach focuses on community based and societal strategies that can effect positive social change. Such an approach means setting priorities that could prevent child maltreatment before abuse or neglect occurs while offering a continuum of services to promote the health and well-being of children. Zimmerman and Mercy recognized that many practitioners and policymakers have implemented prevention strategies outside the child welfare system to many families with young children. However, while many comprehensive public health strategies were in use at the time of Zimmerman and Mercy’s study, these strategies typically did not address problems that were specific to child maltreatment, thus making this a very critical and missed opportunity for intervention.

In their research, Zimmerman and Mercy (2010) added that early traumatic experiences are associated with health problems that continue throughout the lifespan. Moreover, those health problems such as “substance abuse, intimate partner violence, teenage pregnancy, anxiety, depression, suicide, diabetes, ischemic heart disease, sexually transmitted diseases, smoking, and obesity" were associated with child maltreatment (Zimmerman & Mercy, 2010, p. 4). Zimmerman and Mercy suggests that a successful public health strategy would require engaging a host of partners from other service systems and community based resources to address child maltreatment prevention as a public health priority.

Summary and Conclusions

The literature review revealed that children with disabilities are at higher risk of experiencing maltreatment, making them less successful in finding permanent homes than the general foster care population (Bethell et al., 2011; Stalker & McArthur, 2012; Task Force on Health Care for Children in Foster Care, 2005). To address these risks for children in foster care, the literature review presented a theoretical framework comprising the theory of change and social ecological theory. Hernandez and Hodges's (2006) theory of change measured indicators of success for social and political programs and could serve as a roadmap to measure improvements for permanent home placements for children with diagnosed disabilities in foster care. Stokols' (1996) social ecological theory is a set of theories for behavioral and environmental factors used to improve health; thus it can offer individualized strengths based approach strategies to enhance child welfare practice to increase permanent placements for disabled children. This is significant recommendation as the current standards that were written in 1982 are outdated and do not reflect evidence based approaches currently in use to increase permanency for disabled children (see Commonwealth of Pennsylvania Code, 1982; US DHHS ACYF Children's Bureau, 2014). Given the strategies offered by these theories, the work of policymakers and stakeholders within Pennsylvania's child welfare system could potentially focus on changes to address permanent home placements for children with diagnosed disabilities.

The literature review also cited several evidence based policies and program strategies, including the enacted Fostering Connections to Success and Increasing Adoptions Act of 2008, to effectively and safely reduce the number of children in foster care while preventing abuse and neglect, and is a strategy to increase permanent placements for children in foster care. Among the policies and strategies discussed, the US DHHS ACYF Children's Bureau (2014) cited several national outcomes to improve child welfare outcomes. These policies and strategies can address the intent of this study that is to describe ways for the evidence to focus on placement stability for children with disabilities who are in foster care. These findings can help policymakers and researchers develop an in-depth understanding of the effects that diagnosed disabilities has on permanent home placements among children in foster care.

The literature review presented in this chapter revealed a clear pattern in which state laws were driven by federal legislation for state child welfare systems to fulfill the mandated responsibility ensuring the safety of children. The outcomes of this study may suggest social change implications and add knowledge to the existing body of literature, thus providing recommended improvements to the Commonwealth of Pennsylvania's Code that governs the licensing of foster care agencies. In Chapter 3, I will describe the methodology used in the study, the data for conducting secondary analysis, and answers the RQ and testing of the hypotheses.

Chapter 3: Research Method

Introduction

The purpose of this study was to determine whether standards established for Pennsylvania in 1982 identified evidence of whether state licensing code policies were able to determine the relationships that diagnosed disabilities have on and permanent placements. To address this concern, I developed the following RQ and corresponding hypotheses:

> RQ: What impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012?
>
> > H_0-There is no statistically significant impact that children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012.
> >
> > H_A-There is statistically significant impact that children with diagnosed disabilities had on home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012.

The data I gathered pertaining to permanent placement included reunification, living with relatives, adoption, or guardianship for placement stability of children in foster care, while data related to diagnosed disabilities focused on mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically-diagnosed conditions. I used a retrospective method and focused on the foster care program files that matched the target population to represent specific data collected at a point in time for this study. Belli’s (2009) research indicated that specific data collected at “one point in time” can be applied in a study where a retrospective approach is being utilized (p. 66). For this study, files of Pennsylvania’s foster care children that received services during the October 1, 2011 to September 30, 2012 reporting year were selected as the sample for the target population. In the remaining sections of this chapter, I will describe the research design and rationale and methodology (population, sampling and sampling procedures, instrumentation and operationalization of constructs, research instruments) of the study. Also, I will provide further information on the archived data collected, its source, data collection procedures, measures taken to protect the rights of participants, threats to validity, and ethical procedures.

Research Design and Rationale

In this study, I used a retrospective, nonexperimental, quantitative design to analyze and describe data from historical records of Pennsylvania 2012 foster care children. I described data as it exists; no control group, manipulation, changes, or introduction of treatment occurred (see Belli, 2009). The historical records used were the AFCARS archived data of children and youth who spent time in foster care. The US DHHS ACYF Children’s Bureau (2013) reported that historical AFCARS records were used for legislative, programmatic administration and oversight of programs under titles IV-B and IV-E of the Social Security Act to guide child welfare policies. Therefore, I used Pennsylvania’s historical foster care records for secondary analysis in this study to describe the basic features about the sample and the measures being examined as recommended by Quartaroli (2009).

Brown (2009) and Muijs (2011) supported the use of bivariate method to conduct statistical comparisons of two variables to determine whether there are any relationships between them. I used the bivariate method in this study to determine whether there was a statistically significant impact that children with diagnosed disabilities have on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. This approach was chosen because "historical research is to provide more than a simple accounting of what happened in the past; it interprets and explains the past to illuminate the present" (Hines, 2009, p. 145). In support of this retrospective approach, in this study, I looked back in time using historical foster care data files from the 2012 reporting year to explain and explore existing occurrences of diagnosed disabilities in Pennsylvania's children being discharged to permanent home placements.

The dependent variable for this study was permanent home placements classified as the discharged criteria from the AFCARS Data Elements tool for reunification, living with relatives, adoption, or guardianship for placement stability (see AFCARS, 2016; US DHHS ACYF Children's Bureau, 2014). The independent variable was diagnosed disabilities classified as foster care children with mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions (see US DHHS ACYF Children's Bureau, 2014). The covariate variables were (a) Pennsylvania's foster care children who were served during the FFY 2012 reporting year (October 1, 2011 to September 30, 2012); (b) children between the ages of 0 to 6 years old; (c) female and male children; (d) children of all races; (e) the date the child entered foster care; and (f) the date the child discharged from foster care.

Using the retrospective approach and bivariate analysis to gather and describe characteristics of historical foster care records allowed me to answer the RQ. I developed the RQ to statistically compare the two variables to determine what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. There were no time or resource constraints consistent with the choice of design for this study. Lehman, O'Rourke, Hatcher, and Stepanski's (2013) discussed measures of bivariate analysis as an appropriate method to determine relationships and statistically significance between the dependent and independent variables. Their study supports the rationale for using bivariate methods to collect analyze data to test hypotheses or answer the RQ for this study (see Lehman et al., 2013).

My design choice for this study was consistent with research designs needed to advance knowledge in the discipline as it provided a detailed description of categories of data files previously collected on Pennsylvania's foster care children from AFCARS data files, such as race, ethnicity, date of the child's most recent periodic review, child being clinically diagnosed as having a disability, most recent case plan goal prior to leaving placement, and the reason for discharge to a home placement. The categories of AFCARS data files described characteristics and phenomena affecting permanent home placements for children who are between the ages of 0 to 6 years in foster care, particularly among those children discharged from foster care with diagnosed disabilities. I used a retrospective, nonexperimental, quantitative design which was consistent with research designs needed to advance knowledge of Pennsylvania's foster care children.

The US DHHS ACYF Children's Bureau (2012a) mandated that data collection systems of information on children in foster care be placed by states' child welfare or other oversight agency. I chose to use bivariate analyses to gather and assess historical foster care records from Pennsylvania's 2012 outcomes data. This choice was consistent with the research design that was needed to advance knowledge in the discipline and inform gaps in the literature and suggest standards for the Pennsylvania's Code that governs the licensing for foster care agencies to increase permanent home placements among children being discharged from foster care with diagnosed disabilities. The Task Force on Health Care for Children in Foster Care (2005) research findings showed that children in foster care had more predisposed health conditions than the general population. The devastating health effects to these children added further interest to this study about the health of Pennsylvania's with children in foster care. By advancing knowledge in the discipline, the design choice allowed me to prescribe that licensing code for foster care agencies needed to address strategies at the initial foster care placements for children with diagnosed disabilities.

Methodology

I used a nonexperimental, quantitative methodology in this study. Muijs (2011) supported the use of a nonexperimental method for analyzing existing data files and added that quantitative research explains phenomena from numerical data collected and analyzed by using mathematically-based methods. As a result, Muijs proposed bivariate analysis as the method to describe the variables and test the hypotheses from historical data files. Muijs noted that nonexperimental research method allowed theories to be tested and relationships between variables examined and described through statistical measures when looking at the relationships between two variables. As the research design provides the glue that holds the major parts of the research project together, I used a nonexperimental research design to select data of interest for this study as it offers no manipulation, treatment, or random assignments of variables (Belli, 2009). Belli (2009) further noted that the data sampling should be conveniently selected to coincide with the population of interest for the study "to look for changes and not simply report on trends" (p. 67). I will interpret the results in this study and describe ways that the findings confirmed, disconfirmed, or extend knowledge in the discipline by comparing them with what has been found in the peer-reviewed literature.

Population

The population of this study reflected Pennsylvania's foster care children who were discharged to permanent home placements, had diagnosed disabilities, and were between the ages of 0 to 6 years in 2012. I collected the archived source data NCANDS that contains the AFCARS data files for the target population of foster care children. Only the available service case files of the children served within the AFCARS 2012 reporting year that extended from October 1, 2011 to September 30, 2012 were selected for analysis in this study. The service case files that were used in this study included foster care children with diagnosed disabilities, such as mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions, who were discharged to reunification, adoption, guardianship placements, and other relatives in FFY 2012.

The US DHHS ACYF Children's Bureau (2014) reported that as of the last date of FFY 2012, a population of 23,577 Pennsylvania children received child protective services and 36.8%of these children were between the ages of 0 to 6 years. Among the population of children served 14,862 received foster care services; 8,817 children were discharged from foster care to permanent home placements; and of those children discharged, 1,535 had diagnosed disabilities. I identified the sample population of the study as the data files of interest that were studied. The sample population was inclusive of data files representing children discharged from foster care who were between the ages of 0 to 6 years and who had diagnosed disabilities. The analysis conducted by the Children's Bureau in the Child Welfare Outcomes Report did not include an age category for children with diagnosed disabilities (see US DHHS ACYF Children's Bureau, 2014). As the sample population size was unknown, I took several steps to select the relevant characteristics for this study, such as the sampling units or characteristics and sampling frame or population of interest.

The relevant sampling units and sampling frame includes Pennsylvania's foster care children who were discharged to permanent home placements with diagnosed disabilities and were between the ages of 0 to 6 years in 2012. Frankfort-Nachmias and Nachmias (2008) wrote that the sample population size (*n*) is determined by the size of the standard error that is acceptable to the study. Based on Frankfort-Nachmias and

Nachmias’ work, a margin of error shows how close the results being projected is likely to occur. Using the National Statistical Service (n.d.) sample size calculator, a proposed margin of error at 2% with a 95% confidence level has estimated (n = 584) data files as the sample population size for this study. However, from a statistical standpoint, the necessary sample size cannot be calculated if a probability sampling approach is used. The strategies shared by Frankfort-Nachmias and Nachmias were specific for to probability sampling. The nonprobability sampling approach is used to obtain the sample for this study.

Sampling and Sampling Procedures

A nonprobability sampling strategy was selected for this study. The justification for this method is supported by (Belli, 2009; McNabb, 2008) research that it naturally flows from bivariate methods to gather and describe historical records from Pennsylvania 2012 foster care data files. For practical reasons, Belli (2009) and McNabb’s (2008) nonprobability sampling method is being used to the select units for inclusion as it is cheaper, simpler, and more specific, when compared with probability sampling.

The specific procedure for how the sample was drawn began with obtaining an Institutional Review Board (IRB) approval and submitting an application to the NCANDS for access to use archived source of foster care data files. The requested files contained a U.S. population of 638,153 datasets for children served in FFY 2012. A nonprobability sampling procedure was used to conveniently collect the sample of Pennsylvania’s foster care children who were discharged to permanent home placements and who had diagnosed disabilities in 2012 from the population of interest being studied

(Belli, 2009; McNabb, 2008). It is known that while nonprobability sampling represents a valuable sampling technique in research for qualitative, quantitative, and mixed methods research designs, the technique selected may lack diversity and can often be viewed as an undesirable alternative (McNabb, 2008). Nevertheless, Belli's (2009) research supported nonprobability sampling techniques for quantitative studies, as it relied on the judgment of the researcher to purposely select the choice of data files for the sample, without manipulations of treatments or random assignments.

As recommended by Fitzpatrick, Sanders, and Worthen (2010), a nonprobability sampling strategy can conveniently contain units for inclusion in the sample population for this study. The sampling frame inclusion criteria includes data files of (a) Pennsylvania's children foster care served during the FFY 2012 reporting year (October 1, 2011 to September 30, 2012); (b) children whose birthdates show they are between the ages of 0 to 6 years old; (c) children in current placement setting as foster care; (d) children with diagnosed disabilities; (e) children discharged from foster care to adoption, guardianship, parents or caregivers, and any other source; (f) gender as female and male children; (g) race; (h) date entered into foster care; and (i) a date discharged from foster care. Frankfort-Nachmias and Nachmias (2008) wrote that calculating a margin of error can closely project the sample population size for a study. In addition, the National Statistical Service with no date available (n.d.) estimated the population by using a sample size calculator.

The National Statistical Service's (n.d.) calculation for a margin of error set at 2% and a 95% confidence level, could estimate a sample population at (*n* = 584) for the study. Calculating a margin of error may not meet the sampling frame inclusion criteria for this study. Instead, this selection process purposely identified the population of foster care children with diagnosed disabilities from the sampling frame inclusion criteria. The sampling frame exclusion criteria was foster care data files of children older than 6 years.

Suresh and Chandrashekara (2012) shared concerns that determining an optimal sample size may not necessarily reflect findings that are reflective of the population. Nevertheless, Suresh and Chandrashekara advised that a “sample must be ‘big enough’ such that the effect of expected magnitude of scientific significance, to be also statistically significant” (p. 7). Suresh and Chandrashekara’s rationale was that it is more important to have a clear study design, well defined procedures and the appropriate methodology relative to the study intent. Further, as this is a retrospective, nonexperimental quantitative study, the research design involves the use of bivariate method for gathering AFCARS historical records to describe characteristics of foster care children, tabulate and describe data patterns and relationships that emerge during the analysis (Belli, 2009; Brown, 2010; Muijs, 2011; Quartaroli, 2009; US DHHS ACYF Children’s Bureau, 2013).

A nonprobability sampling method was used to select the sample population and it does not involve random selection and may not be necessarily representative of the population (Belli, 2009; Muijs, 2011). However, Belli (2009) supported the use of purposive sampling to select the predefined sampling frame inclusion criteria for the sample population. The rationale for selecting the characteristics identified for purposive sampling is twofold; first, to describe patterns that might emerge from the data, and second, to describe what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012.

Using Archival Data

Prior to the start of the study, the procedure for recruitment and collection of historical records associated with the study began with permission from the national data collection, analysis, and reporting system for the NDACAN, at the Bronfenbrenner Center for Translational Research located in the College of Human Ecology at Cornell University in Ithaca, New York (US DHHS ACYF Children's Bureau, 2013). The website of NDACAN AFCARS Child File Data Ordering Instructions indicated that the process of obtaining permission could take a week for the delivery. This timeline was to ensure that the application package was complete as it contains the Application for Dataset: National NDACAN AFCARS Child Files and Terms of Use Agreement.

The NDACAN's website stated that data files were made available to the research community for secondary analysis of AFCARS archived data files that were relevant to the studies pertaining to child abuse and neglect and foster care (AFCARS, 2016; NDACAN, n.d.). The US DHHS ACYF Children's Bureau (2013) added that restrictions to case-level data files were in place that may expand the timeline to retrieve data files. From the approval granted to assess NDACAN AFCARS Child Files, historical data were gathered and analyzed to answer the RQ, as well as test the hypotheses for this study. Historical and legal documents from the US DHHS ACYF AFCARS that were previously analyzed were the source of data files used for this study (US DHHS ACYF

Children’s Bureau, 2010a). This national archive is a source of scholarly exchange among policymakers, child welfare practitioners, researchers conducting secondary analysis, and other concerned citizens (US DHHS ACYF Children’s Bureau, 2010a). These child files were verified as being reliability and reputability and the best sources of data on child abuse, neglect, and foster care; through repeated national use and pilot tests (AFCARS, 2012).

Instrumentation and Operationalization of Constructs

Published instrument this for study. States are required to use the AFCARS Data Elements Instrument to collect and report case specific data twice per year at two 6-month reporting intervals. The case specific data were for all children for whom the state’s child welfare agencies had responsibility for placement, care, or supervision. Through efforts of the Children’s Bureau, data files were analyzed, disseminated, and key findings were published annually in the *Child Maltreatment* and *Child Welfare Outcomes Reports to Congress* (US DHHS ACYF Children’s Bureau, 2013, 2014). The US DHHS ACYF Children’s Bureau (2013) reported that the *Child Maltreatment 2012* was the 23rd publication of this report.

There is evidence of appropriateness for the use of AFCARS data files for this study. The US DHHS ACYF Children’s Bureau (2013) reported that data elements were designed to address states and federal government policy development and program management issues that are relative to the aspects of foster care and adoption programs. The NDACAN website reported that this data archive has been a resource since 1982, and is authorized to collect national data on foster care and adoption of children for the

US DHHS ACYF Children’s Bureau, through a grant from the American Public Welfare Association to the NDACAN.

The AFCARS Data Elements Instrument can generate relevant data from the sample population such as: (a) the state providing foster care services; (b) child's foster care service date; (c) child’s age between 0 to 6 years old; (d) child’s current placement setting as foster care; (e) child’s diagnosis of a disability; (f) child’s discharge from foster care to adoption, guardianship, parents or caregivers; and any other source; (g) child’s gender; (h) race; (i) date entered foster care; and (j) date discharged from foster care.

Miller et al. (2009) wrote that the method by which a measurement instrument is constructed, validated, and standardized should contain “reliable and valid measures of relevant constructs” for the research (p. 21). For this study, the AFCARS Data Elements Instrument is the data collection tool, as it was created and has been utilized by the Children's Bureau for many years. The Bureau reported that the AFCARS Data Elements Instrument is used to assess the accuracy, efficiency, and effectiveness of states data collection, extraction, and reporting processes (US DHHS ACYF Children’s Bureau, 2012a). Reliability and validity values relevant to this study were published in the editions of *Child Maltreatment 2012* and *Child Welfare Outcomes 2009-2012: Report to Congress* (US DHHS ACYF Children’s Bureau, 2013, 2014). These reports provided states data and other important information, such as detailed descriptions of the data measures and analyses, changes in performance measures over time, and summaries of data findings. States were mandated to partner with the Children’s Bureau for ongoing technical support to improve data quality, validity, and reliability of the data collected and reported to the NDACAN website. The child welfare summary for the 2012 end of year report showed that Pennsylvania provided statewide services to an estimated number of 14,862 foster care children (US DHHS ACYF Children's Bureau, 2014).

State data collected from the AFCARS Data Elements Instrument were used to write the *Child Welfare Outcomes 1998: Annual Report*, the first in a series of 23 annual reports and were required by the ASFA (US DHHS ACYF Children's Bureau, 2000, 2014). The Children's Bureau reported that this instrument was previously used to collect and present data on states' performances in meeting the needs of children and families that were served through the child welfare system. The instrument has since been used annually, to collect and present data on states performance, to assist in policy development and program management by policymakers at the federal, state, and tribal levels to prevent unnecessary placement of children into foster care (US DHHS ACYF Children's Bureau, 2014). Validity and reliability was determined in the first report that established baseline performance measures that states were supposed to measure from data that were available on that measure and the extent to which the instrument yielded the same results from available data each year.

Researcher's instrument for this study. The AFCARS Data Elements Tool for this study is the federally mandated instrument used to collect case specific information about children served by states' child welfare agencies (AFCARS, 2013). The US DHHS ACYF Children's Bureau (2013) stated that the children served had at least one report of maltreatment and received one or more interventions from the child welfare system. The foster care data files portion of the AFCARS tool collects demographic information, service goals while in foster care, reasons for discharge from foster care, and whether a qualified professional had clinically diagnosed the child as having a disability. The basis for the development of the AFCARS instrument used for this study was for states' child welfare agencies to have a standardized process that could ensure the accuracy and reliability of the foster care and adoption data used by the Children's Bureau (AFCARS, 2013). In addition, the instrument measured whether states had attained the national outcome goals to achieve safety, permanent placements, and well-being for the child welfare programs (AFCARS, 2013).

The US DHHS ACYF Children's Bureau (2000) reported that the baseline performance measures were established for states to use annually in assessing their progress towards (a) reduced recurrence of child abuse and/or neglect, (b) reduced the incidence of child abuse and/or neglect in foster care, (c) increased permanent placements for children in foster care, (d) reduced time in foster care to reunification without increasing re-entry, (e) reduced time in foster care to adoption, (f) increased placement stability, and (g) reduced placements of young children in group homes or institutions measures in annual reports from the Children's Bureau. States were presented with performance data of these seven outcomes in meeting relative to the needs of children and families who were served by the child welfare system. *The Child Welfare Outcomes Annual Report* focused specifically on the aggregate outcomes or results of services for all states and did include outcomes of interest to the RQ for this study.

The evidence of reliability was the degree to which the AFCARS Data Elements tool yields consistent results whenever repeated testing was conducted. The AFCARS

Data Elements Instrument cited in this study was used annually by the NDACAN since 1998, to collect uniform and reliable information on children who were the responsibility of state welfare agencies. These and other information are distributed annually in the *Child Welfare Outcomes Report* with regulations to improve services and outcomes for abused and neglected children, children in foster care, and children awaiting adoption (US DHHS ACYF Children's Bureau, 2014).

This study did not provide evidence for predictive validity, as it is to determine effective steps to be recommended for the improvement of Pennsylvania's licensing code. These steps may assist foster family care agencies to collect state and national outcomes data for increased permanent placements for foster care children with diagnosed disabilities and are being discharged from foster care. The evidence of construct validity in the study demonstrates how the sample size was conveniently selected. Therefore, the sample size for this study was conveniently selected from the historical data files of foster care children. Historical data files of foster care children seemed to be credible and trustworthy, as the data were published annually in reports to enforce federal laws and regulations (US DHHS ACYF Children's Bureau, 2012a).

According to Barry, Chaney, Piazza-Gardner, and Chavarria (2014), an instrument by itself is not deemed "valid or reliable;" instead, it is the content or data produced in an article or report that has validity and reliability (p. 12). The AFCARS Data Elements Instrument performed consistent and regulatory activities by collecting case-level information from state and tribal Title IV-E agencies. AFCARS (2013) reported that case files for children in foster care and adopted households were collected twice yearly based on two 6-month reporting periods. Based on Barry et al.'s (2014) research, the annual *Child Welfare Outcomes Reports* were deemed credible and reliable as the findings from these reports offered strategies for improvements and recommendations about ways to eliminate abuse and neglect in the child welfare system (US DHHS ACYF Children's Bureau, 2014). As the use of this instrument provides consistency and validity, statistical operations with historical data may be able to answer the RQ and hypotheses. The AFCARS (2012) reported that the Children's Bureau created the AFCARS instrument as an assessment review tool for collecting quality data and that its outcomes were used for policy development, program management and evaluation at the states performance.

Operationalization

The variables were identified in Chapter 1, discussed in depth through the literature review presented in Chapter 2, as these variables were among the national and state performance standards measured in seven outcome categories to improve services for children and families in the federal data reporting systems. An increase in permanent placements for children in foster care is the operational definition for the dependent variable for this study. The dependent variable was measured to determine the success rate of a child's discharge to reunification, adoption, guardianship, and other relatives (see US DHHS ACYF Children's Bureau, 2014). The US DHHS ACYF Children's Bureau reported that in the FFY 2012, states had 87.3% success rate in permanent placements for all children that were discharged from foster care to reunification, adoption, legal guardianship, or with other relatives. The report also indicated that states' performance varied from 29.7% to 34.4% for children who were in foster care for periods of 24 months or longer. Furthermore, the report concluded by noting that states had difficulty finding permanent placements for children who stayed in foster care longer than 24 months.

Having a diagnosed disability was the operational definition for the independent variable of this study. This variable was measured to determine the level of success that Pennsylvania had in achieving permanent homes for children leaving foster care with a diagnosed disability of mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions. The findings from the analysis of the two variables simultaneously, helped to answer the RQ of what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012.

The US DHHS ACYF Children's Bureau (2000) reported that increasing permanent home placements for children leaving foster care is a federal performance measure, while achieving permanent homes for children leaving foster care with a diagnosed disability was to help states alleviate disparate gaps in care. The measure of success for children achieving a permanent home was compared to a national success rate of 87.3% in 2012 (US DHHS ACYF Children's Bureau, 2014). In a similar way, the measure of success for the independent variable was calculated to determine if the percentage of all children who were discharged from foster care during 2012, had a national success rate of 77.7% in 2012. The variables were not to be manipulated; rather a bivariate method was used to summarize and describe the quantitative data files between the dependent and the independent variables in a meaningful way.

Data Analysis Plan

The analysis process began after the AFCARS historical case files were received, in SPSS software tables used for statistical analysis from the NDACAN. Data cleaning and screening procedures were necessary to identify and minimize any affect that the AFCARS case files could have on study results. Broeck, Cunningham, Eeckels, and Herbst (2005) noted that data cleaning strategies were intended to identify the presence of incorrect or inconsistent data that could significantly distort the results of analyses and the potential benefits of information-driven approaches from the study. Also, analysis from Sedlak et al. (2010) reported that the data processing steps used in national incidence studies of child abuse and neglect to Congress included the data retrieval, cleaning processes, basic and evaluative coding. Sedlak et al. also reported that child records were un-duplicated and weighted to eliminate errors, and were consistently collected to develop national estimates and variances. This study intends to be responsible for data cleaning and screening procedures and provide feedback to the NDACAN on any errors or omissions identified with the data. The current AFCARS Data Elements Instrument contains coded descriptions assigned to represent responses to the RQ and testing of the hypotheses.

The study adopted an open coding method to review archival data. Rudestam and Newton (2007) shared that an open coding method would allow for saturation of data elements beforehand to identify all possible areas of analysis for this study. Smith et al.

(2011) shared that the same basic research principles that were applicable to primary data analysis would apply to secondary data analysis, including the development of a clear and relevant RQ, study sample, appropriate measures, and analytic approach. To maintain some neutrality and validity for the study, the AFCARS historical data files from NDACAN was not manipulated or treated as the data files for this retrospective, nonexperimental quantitative study were received in a SPSS format. NDACAN conducted the data cleaning and screening procedures that I used to match the same data quality and standard needed to answer the RQ and hypotheses in this study (AFCARS, 2016b).

Adams-Huet and Ahn (2009) offered steps to consider in preparing a data analysis plan. Adams-Huet and Ahn added that the analysis plan should be driven by the RQ and hypotheses, study design, types of the outcome measurements, assignment of subjects, description of variables and demographic description. The data analysis plan addressed any inadequacies and ownership of archived data files during the inquiry with the NDACAN. The advantages in using the AFCARS Data Elements Instrument are that data files are expected to contain coded descriptions assigned to represent responses to the variables in the RQ.

Characteristics from the AFCARS Data Elements Instrument that identified the study sample was requested in an IBM SPSS Statistical software format and then verified that coding were retained and accurately matched those being transcribed for analysis. The IBM SPSS Statistical software analyzes quantitative data into pivot tables consisting of columns and rows that can quickly summarize the historical data and highlight the desired characteristics from the AFCARS Data Elements Instrument. The SPSS software also provided the ability to filter data from drop down listings, rearrange the fields displayed in rows, columns, and data items to get different views of the same data. The use of pivot tables allowed columns and rows to be dragged-and-dropped in a trial-and-error fashion to show some immediate results, as well as to generate and extract meaningful information from a large table of information. Once data were downloaded into tables, it was copied to a Microsoft EXCEL spread sheet for further organization and display, as needed.

Archived data from NDACAN explored important issues related to increased permanent placements in foster care for children being discharged from the program who had diagnosed disabilities. Statistical tests are used to test the hypotheses and analyze and interpret numerical data to determine the relationships between the variables. Belli's (2009) research supports the use of statistical tests for testing the hypothesis by examining the characteristics of the data variables with scatter plots, correlations, relationships of variability, and cross-tabulations. To promote a structured and targeted data analysis, SPSS software provided data with simple graphic analysis, such as histograms to describe differences that may have existed between the variables in the data files (Hines, 2009). The SPSS data being evaluated from NDACAN includes AFCARS data files that were outlined in the Instrumentation and Operationalization of Constructs section.

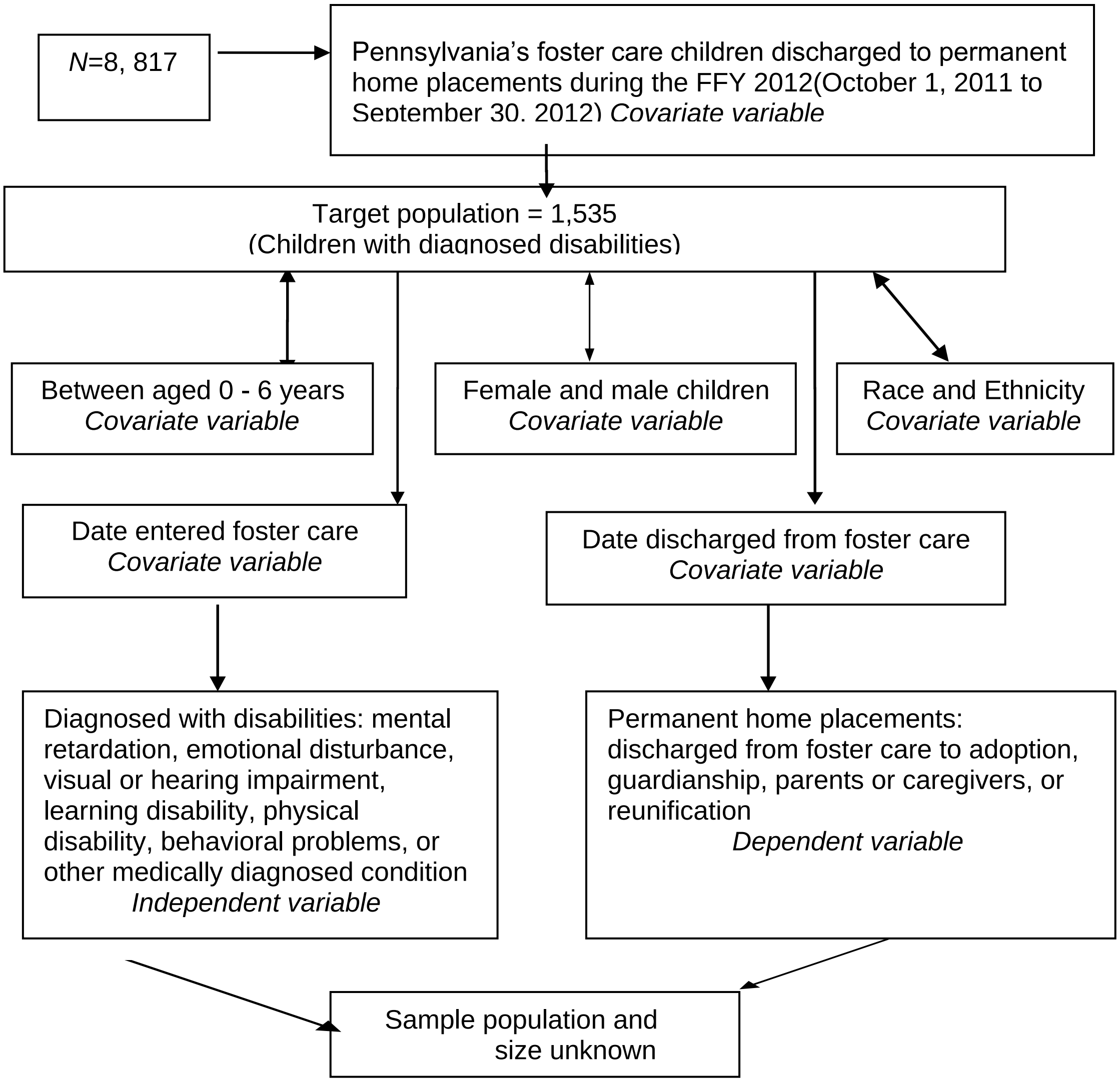

*Figure 1.*Quantitative analysis path diagram for this study.

The use of bivariate analysis is best suited for analyzing archived foster care data for relevant attributes within the sample population (Belli, 2009; Muijs, 2011). The relevant AFCARS data files were quantified and described in meaningful ways to show the frequencies, mean, and use of histograms to combine data into groups of foster care children without showing any conclusions about the sample size. Rudestam and Newton (2007) explained that researchers must assume responsibility for the adequacy of archived data, as data files often had missing, inadequate, and incomplete data, and often the ownership and control of analysis results are sometimes debatable.

The procedure to account for the multiple statistical tests for this study includes the use of SPSS. While this is not a statistical test, this mathematical procedure can describe case specific information on the entire dependent and the dependent variables and outputs such as, the standard deviation, variance, frequency distribution, and central tendencies (Babbie, 2007; Brown, 2010; Muijs, 2011). Having covariate included in the study serves as a secondary variable to help describe the connections between the dependent and the independent variables of primary interest. Fan (2010) wrote that a covariate is like an independent variable, as it is measurable, and is considered to have a statistical relationship with the dependent variable. Fan added that covariates were possible predictive or explanatory variable of the dependent variable. Used in this context, the covariates of interest include (a) Pennsylvania’s foster care children served during the FFY 2012 reporting year (October 1, 2011 to September 30, 2012); (b) female and male children between the ages of 0 to 6 years old; (c) date child entered foster care; and (d) date child discharged from foster care.

Estimates from the data analysis can interpret key parameters such as the mean, variance, or *t*-score. The results of these parameters described what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. Any evidence of reliability for this study was shown through consistency or dependability of repeating the same measure to produce similar results under consistent conditions. Studies are more inclined to be reliable if the results were consistent each time that the measures were repeated (Babbie, 2007; Belli, 2009). Furthermore, Belli (2007) added that validity of the measure should be established. This means that the analysis conducted on foster care sample data should measure what it was intended to measure and represent the overarching quality of the measure. Also, being able to consistently achieve the same results time after time can provide test-retest reliability and internal consistency of the results among the variables being assessed (Huet & Ahn, 2009).

It was anticipated that data files from the AFCARS can sufficiently answer the RQ and test the hypotheses by using a convenient sampling process to select a precise data file that is a representative sample for this study. The data sampling is inclusive of (a) Pennsylvania's foster care children who were served during the FFY 2012 reporting year (October 1, 2011 to September 30, 2012); (b) having birthdates between the ages of 0 to 6 years old; (c) identified with diagnosed disabilities; (d) increased permanent placements for children discharged from foster care to adoption, guardianship, parents or caregivers, and any other source; (e) gender as female and male children; (f) race; (g) date child entered into foster care; and (h) date child discharged from foster care (US DHHS ACYF Children’s Bureau, 2014). As this is a retrospective, nonexperimental quantitative study, only naturally existing attributes are identified and analyzed once the archived data files were collected to support the sample population.

Threats to Validity

Background and historical finding on AFCARS Data Elements Instrument identified reliability and validity concerns within the collection of national data on foster care and adoption data files had several flaws including “variation from state to state in reporting periods, a lack of common definitions for data elements and services, and inconsistent methodologies in reporting” (AFCARS, 2012, p. 2). Since the December 22, 1993 final ruling to implement the AFCARS data collection system, federal mandates have led to “recommendations for establishing, administering, and financing a system for collecting data on adoption and foster care in the United States” (AFCARS, 2012, p. 2). The threat to external validity of this research was the use of archived data previously collected by multiple foster care agencies from 67 counties across Pennsylvania, as a part of the AFCARS child files that are reported to NDACAN. While efforts are made to create the cleanest, most reliable and up-to-date data files for analysis, AFCARS reports that anomalies may still existed in the data. As a result, the users of the data files were encouraged to examine all the data elements being used in their analyses. Other potential threats to external validity were that the records could be biased, the data files could be at the mercy of whoever collected the data, and the data files collected may, or may not; ask what was needed for the study.

Further, Belli (2009) emphasized that the consistency or dependability of a measure is testament to its reliability. The mandatory reporting system established by the U.S. Congress, is a national archive for child abuse and neglect data among adoption and foster care children. While AFCARS data collection system did not conform to rigorous criteria for scientific research design, its specific objectives provided reliable and consistent data using uniform definitions, methodologies, and data standards (AFCARS, 2012). AFSCAR (2012) reported that the data collection system also provided reliable and consistent state and national information on the number and characteristics of adoptive and foster care children and their parents, the status of the foster care population (i.e., type of placement, length of placement, availability for adoption, and goals for ending or continuing care), as well as the assistance provided by federal, state, and local adoption and foster care programs.

The US DHHS ACYF Children's Bureau (2013) stated that the national and state statistics were collected through the NCANDS of the Children's Bureau. In return, NCANDS had responsibilities to provide technical assistance to support improvements of data quality from the states. Keeping in line with Belli's research, there were expected reliability and validity from the AFCARS data instrument as the measures collected were consistent with each other and across states. Further, if the AFCARS data measures were used repeatedly by other researchers, these results were expected to produce similar results with each analysis. The concepts being measured in this study would consistently describe what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. The data files pertaining to permanent placements assessed for discharges to reunification, living with other relatives, adoption, or guardianship for placement stability of children in foster care, while those data files relating to diagnosed disabilities assessed for documentation of mental retardation, visual or hearing impairment, physically disability, emotionally disturbance, or other medically diagnosed conditions.

There were no threats to internal validity for this retrospective, nonexperimental quantitative study. This investigation assessed historical record using bivariate analysis methods to assess the relationship between the dependent and the independent variables in order to test the hypotheses for any degree of association, statistical significance, and strength that exist between the variables (IBM Corporation SPSS Statistics Part 2, 2016b). As cited in Chapter 1, Gravetter and Forzano (2012) wrote that nonexperimental studies were used simply to describe possible differences that exist within the RQ. Based on Gravetter and Forzano analysis, any statistical conclusions provided would be the degrees to which conclusions are about the relationship among variables based on the data are reasonably correct.

Threats to statistical conclusion validity is not expected in this study, as, Garcia-Perez (2012) wrote that the conclusions of a research should be founded on an adequate analysis of the data; generally meaning that if adequate statistical methods were used the more accurate the answers were to the RQ. A breach of this validity would also occur when there was no control of Type-I or Type-II errors. Garcia-Perez recommended statistical regression to investigate bivariate relationships and to assess validity.

Experimental mortality and selection-maturation interaction are not threats to the internal validity for this study. Mertens (2014) wrote that experimental mortality threats were concerned with participants drop out of a study, while selection-maturation interaction threats could result from bias when variables were compared within a sample population. This retrospective, nonexperimental, quantitative study assessed historical case-level data files for children served by the foster care system in 2012.

Ethical Procedures

The actual documents included in the Research Ethics Review Application to the Walden University IRB addressed the ethical procedure processes to request approval to conduct this research study. Treatment of human participants was not a factor, as this study conducted secondary analysis of historical data and procedural requirements were addressed in the IRB application. Nevertheless, measures were taken to understand the process of protecting participant's rights. As a prerequisite for conducting study, a Certificate of Completion from the National Institutes of Health (NIH) Office of Extramural Research certified that the NIH Web-based training course "Protecting Human Research Participants" was successfully completed on 05/24/2012, with a Certification Number: 925515, a copy was submitted with Walden's IRB Application. An email confirmation receipt was issued on 8/92016, by Walden University's IRB Office of Research Ethics and Compliance. The approval number is 0114393 and it is for me to conduct community research with the NDANDS.

There are no ethical concerns related to recruitment of materials as the processes were in place to address the receipt of NDACAN materials for this study. While data files being requested were de-identified and archived for conducting secondary analysis, the NIH Web-based training course emphasized that systematic and rigorous protection should be given to human research participants (NIH Office of Extramural Research, 2008). The ethical concern for this study is related to the AFCARS data collected as factors may or may not have been in place to protect vulnerable foster care children, ensuring that "potential benefits outweigh considerations of risks and vice versa" in this research (NIH, Office of Extramural Research, 2008, p. 19). The AFCARS' (2016b) user's guide provided the proper format to acknowledge the publication and use of national data files. The NDACAN wrote that users should acknowledge that data were made available through the NDACAN as the original collector of the data files. The AFCARS urged users to adopt the following statement:

> The data used in this publication were made available by the National Data Archive on Child Abuse and Neglect, Cornell University, Ithaca, NY, and have been used with permission. Data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) were originally collected by the Children's Bureau. Funding for the project was provided by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The collector of the original data, the funder, the Archive, Cornell University and their agents or employees bear no responsibility for the analyses or interpretations presented here.
> (Acknowledgment of Source section, para. 2)

Just as it is important to acknowledge the NDACAN as the original collector and source of the archived data files for this study, it is equally important that users of the data files had to adhere to the "Terms of Use Agreement" that states "users of these data are required to deposit a copy of any published work or report based wholly or in part on these data with the Archive" (AFCARS, 2012, p. 1). Additionally, as a prerequisite for conducting study, this researcher completed the research ethics training module and a copy submit of the Human Research Protections training certificate was submitted with Walden's IRB Application as requested. Furthermore, the American Psychological Association (2010), "Figure 8.2. Compliance with Ethical Principles Form" stipulated that the protection of confidential data should be addressed with the proposal submission (pp. 233-234). For this study, the stipulation for compliance with ethical principles was addressed in the Research Ethics Review Application to the Walden University's IRB.

States were required to collect and submit up to 100 case specific data elements or variables electronically to the Children's Bureau for all children in foster care for whom the state child welfare agency had responsibility for supervision and placement (AFCARS 2013). Once permission from NDACAN was granted to access archived data, anonymity and confidential treatment of data was of utmost concern. Before the AFCARS data files were distributed for secondary analysis, NDACAN made certain manipulations to the foster care files to protect the privacy of the children in foster care. Manipulations such as the removal of county files with fewer than 1,000 records and issuance of the version files containing the most complete and accurate data were made available. For example, a “file named *FC2009v2* would therefore contain the second version of fiscal year 2009’s foster care data” (AFCARS, 2013, p. 7).

The foster care data files containing up to 100 variables (73 original variables and 27 NDACAN-derived variables) were anonymous and confidential data files of AFCARS Data Elements without recording of identifying information. Protections for confidential data were in place; once data files were received electronically from the NDACAN to a personal Laptop, data storage procedures ensure files were protected and stored by password access. Whenever the electronic files were not in use, they were stored on personal Laptop, and kept in a locked file cabinet in my home or work office. The key was available only to the investigator and no one else had access to electronic or paper records. There was no expected identifying information received with electronic files as the historical data files were de-identified by the NDACAN before its distribution. No data dissemination occurred and the investigator for this study was the only one to have access to the historical data files.

While Walden University minimum requirements require that data files be kept securely for five years, NCANDS’s duration for license goes into effect upon the granting of approval, and remains in effect for 36 months or until the completion of the research project, whichever comes first (NCANDS Child File Data License, 2013). A new license would be required if further access was required beyond the timeline (NCANDS Child File Data License, 2013). This investigator agreed not to store the NDACAN data on a networked computer or other electronic storage device without protecting the device from unauthorized access and assigning appropriate protections such as password security, virus protection, and firewall.

This investigator protected the NDACAN data from access by unauthorized individuals by keeping computers and portable data storage devices in locked offices or filing cabinets. As the authorized data user, this investigator did not lend, convey, or copy data file to anyone. In addition, NCANDS required that upon completion of the research, "the Investigator will return the NCANDS Child File Master CD to the Archive and notify NDACAN that all copies of the Restricted Data, or whatever media, have been destroyed" preventing future extraction or reconstruction (NCANDS Child File Data License, 2013, p. 2). The electronic and paper data results will be kept for 5 years to answer any questions that may arise concerning the study. At the end of the five years, all electronic and paper data are then destroyed. There are no known ethical issues or concerns applicable for this study.

Summary

Chapter 3 provided a complete disclosure of the methods and procedures that were used to conduct this retrospective, nonexperimental quantitative study. Chapter 3 also outlined the research methodology for the research design and rationale that was used to obtain and process historical data files to answer the RQ and associated hypotheses. The population, sample size, and sampling procedures were discussed, along with the data collection processes that were used to access the historical data files. The tool and techniques to identify and examine the study variables for relationships between permanent placements and disabilities were described for the study.

Research discussed in Chapters 1 and 2 shared that children entering foster care had higher occurrences of behavioral, developmental, and health conditions than non-foster children and were even more predisposed to chronic and persistent conditions that led to an accumulation of unpleasant events and unmet needs. This retrospective, nonexperimental quantitative study described what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. The results from population statistics of the number, race, age, median length of stay of children in foster care, placement to permanent residence, and exits of children with diagnosed disabilities were described from this study. The research design provided a description for archived analysis from a sample of the 2012 Pennsylvania foster care archived data files from the NDACAN and the relationships that the variables may present.

In support of Walden University's *2011 Social Change Impact Report*, there are many implications for social change that may result from the findings in this study. The results of the study may support the need for increased placement stability as an important issue due to a high number of children remaining in foster care each year. The results may support a need to lessen the occurrence of child displacements in permanent placement planning by increasing their transition into permanent family homes, instead of moving them to substitute care. Findings from data which was analyzed may support a need for earlier mental and behavioral health interventions, as studies throughout the proposal addressed child behavior problems as one of the strongest predictors of placement instability.

Significant social change is anticipated through the distribution of technical reports and presentations of the resulting data at professional meetings; and with the NDACAN, Pennsylvania Department of Human Services, public, private organizations, and community groups to help meet the challenges faced by children and their families. Implications for positive social change should be anticipated through changes that inform policymakers, foster care and adoption agencies, and families, about the importance of increasing the stability of permanent home placements for children being discharged from foster care.

Chapter 4: Results

Introduction

The purpose of this study was to determine whether standards established for Pennsylvania in 1982 identified evidence of whether state licensing code policies were able to determine the relationships that diagnosed disabilities have on and permanent placements. To address this concern, I used a retrospective, nonexperimental, quantitative study design. I used guidelines for quantitative research and bivariate analysis to examine statistically significant relationships between the independent and the dependent variables (see Belli, 2009; Brown 2010; IBM Corporation SPSS Statistics, 2016a, 2016b, 2016c; Muijs, 2011). I developed the following RQ and hypotheses to guide this study:

> RQ: What impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012?
>
>> H_0- There was no statistically significant association that children with diagnosed disabilities had on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012.
>>
>> H_A- There was a statistically significant association that children with diagnosed disabilities had on home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012.

Chapter 4 will contain three sections. In the first section, I will describe the time frame and protocols for data collection, recruitment, and discrepancies in data collection from the plan I presented in Chapter 3. The section will include descriptive statistics of demographic characteristics for the sample data of interest. A description of the nonprobability sampling and its proportionality to the larger population, along with the results of the bivariate analyses justifying the inclusion of covariates will also be summarized. The second section will include results of descriptive statistics of the sample, statistical assumptions, and analysis findings that are organized by the RQ and hypotheses. Results of analysis and statistical tests that emerged from the sample will be illustrated in tables and figures. In the final section, I will summarize the findings related to the RQ.

Data Collection

The data collection time frame I used for this study occurred during the FFY 2012, from October 1, 2011to September 30, 2012. The actual recruitment began with my contacting of the US DHHS NDACAN, at the Bronfenbrenner Center for Translational Research located in the College of Human Ecology at Cornell University in Ithaca, New York. States have the federally-mandated responsibility to collect and report child welfare data (AFCARS, 2016). The NDACAN acts on behalf of the Children’s Bureau, Administration for Children, Youth and Families, to distribute AFCARS data files to the research community (AFCARS, 2016). It took 1 week for the delivery of the archived data files, after I submitted the *Terms of Use Agreement* application to the NDACAN. Data files were retrieved electronically from the NDACAN box.com link, and I used IBM SPSS software, Version 23 to abstract AFCARS foster care variables by position.

Population Dataset

IBM Corporation SPSS Statistics, Part 2 Descriptive Statistics (2016a) characterized the measurement scales in the study. Several analysis tables compared factors associated with children in foster care who were served in the FFY 2012--the length of stay (in days) in current placement setting, gender, age, and derived race and ethnicity variable--to explain the impact that the independent variable had on the corresponding variable. Figure 2 represents updated AFCARS child files from NDACAN that I used for descriptive and frequency analysis for the population and inclusion criteria. The results from descriptive statistics corresponds with the population of interest for my study and are displayed in Tables A1–A6 (Appendix A) that shows (a) the US population of children served, (b) Pennsylvania children served, (c) foster care placements, (d) permanent home placements, and diagnosed disabilities. Belli (2009) wrote that data sampling should be appropriately selected to correspond with the population of interest for a study. Based on Belli’s recommendation, the data sampling I used in this study was chosen from a single point in time with a snapshot of conditions present at that instance. I presented my data sampling plan in Chapter 3, and I followed that plan using nonprobability sampling methods in the study. Belli’s and McNabb’s (2008) methods supported this use of purposive sampling, as a type of nonprobability method used in sampling and identifying data for this predefined group of children in foster care.

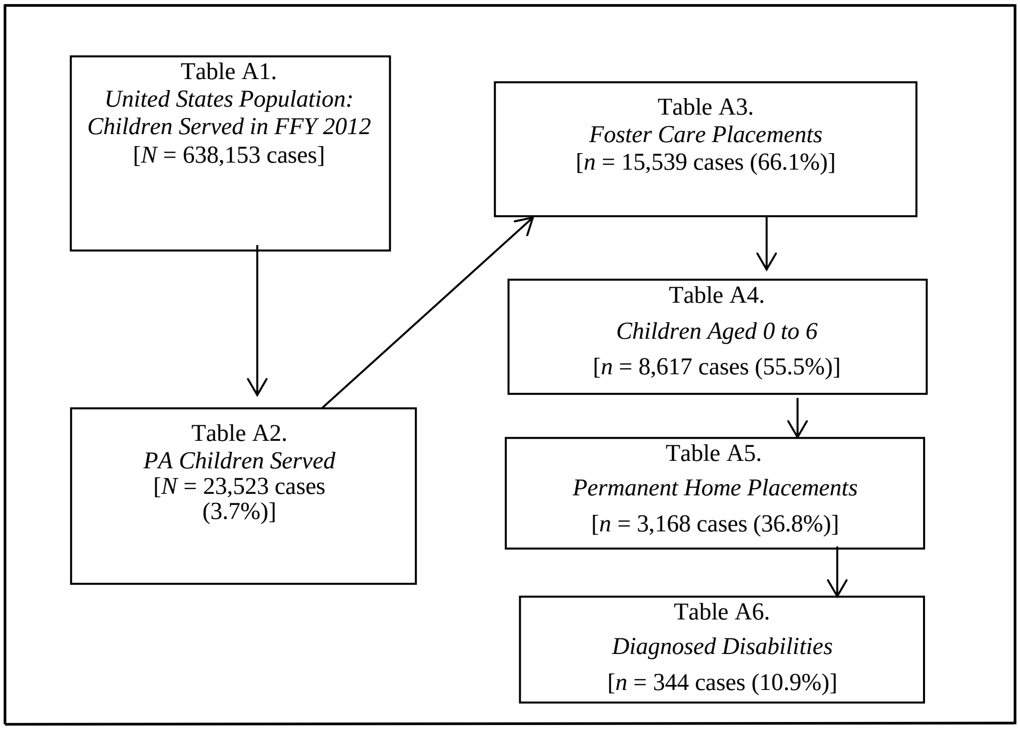

Figure 2. Summary of U.S. population of children served in FFY 2012.

The steps shown in Figure1illustrate how I analyzed demographic characteristics and identified foster care children discharged to permanent home placements and who were between the ages of 0 to 6 years with diagnosed disabilities in 2012. The purposeful sampling from the updated NDACAN AFCARS Child Files resulted in the extraction of 23,523 case files of Pennsylvania's children served in FFY 2012. Among these children: 15,539 (66.1%) received services in foster home placements; 8,617 (55.5%) of those in placements were aged 0 to 6 years; 3,168 (36.8%) of those aged 0 to 6 years were discharged to permanent home placements; and 344 (10.9%) of children discharged had clinically diagnosed disabilities. The sample population (*n* = 344) 1.46%, is proportional to the Pennsylvania's child welfare population who were served at some point during the FFY 2012. There was no discrepancy in data collection from the plan I presented in Chapter 3 from the NDACAN AFCARS Child Files.

Sample Dataset

The statistical data sampling for Pennsylvania's children in foster care were inclusive of those: (a) discharged to permanent placements such as reunification to parents or caregivers, living with relatives, adoption, or guardianship and (b) children with diagnosed disabilities such as mental retardation, visually or hearing impairment, physical disability, emotional disturbance, or other diagnosed conditions. In the sampling of AFCARS Child Files, I purposely analyzed baseline descriptive statistics and selected demographic characteristics for the dependent and the independent variables for the study using IBM Corporation SPSS Statistics, Part 1 (2016a) as shown in Tables 1–9. Table 1 represents the analysis results of 344 children with clinically-diagnosed disabilities. Within this table, other diagnosed conditions represent the largest sample (M = 0.68, s = 0.466) of children (n =235).

Univariate analyses justifying inclusion of covariates. In Appendix A, the U.S. population of children served in FFY 2012 represents the results of basic univariate analyses to justify the inclusion of covariates in this study. The analysis of the statewide population data led me to make changes in two covariates from the Chapter 3 plan. First, the covariate stated as the date the child entered foster care was not a relevant data sampling criterion (see AFCARS, 2016). In its place, the codebook variable, length (in days) in current placement setting, provided the number of days between current setting date in foster care and the date children were discharged (see AFCARS, 2016). Second, the covariate of the date the child discharged from foster care was eliminated, as it was not a measure to increase permanency for children in foster care. The remaining covariates of interest that were relevant to complement the dependent variable included (a) Pennsylvania's foster care children who were served during the FFY 2012, (b) children aged 0 to 6 years old, (c) female and male children, and (d) children of all races.

Table 1

Children with Diagnosed Disabilities

	Sum	*M*	*SD*	Variance
Mental retardation	14	.04	.198	.039
Visually or hearing impaired	10	.03	.168	.028
Physically disabled	73	.21	.409	.168
Emotionally disturbed	41	.12	.324	.105
Other diagnosed condition	235	.68	.466	.217
Total	344			

Note. From Table A6 in Appendix A; *M* = mean; *SD* = standard deviation

Table 2

Race and Ethnicity by Gender

		Child Sex		
		Male	Female	Total
Derived Race/Ethnicity Variable	Non-Hispanic (NH), White	120	87	207
	NH, Black	44	31	75
	NH, Am Ind AK Native	0	1	1
	NH, Asian	4	1	5
	NH, More than One Race	10	3	13
	Hispanic (Any Race)	15	21	36
	Race/Ethnicity Unknown	4	3	7
Total		197	147	344

Table 3

Children Aged 0 to 6 at the End of FFY 2012, or at Exit

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	29	8.4	8.4	8.4
	1	82	23.8	23.8	32.3
	2	85	24.7	24.7	57.0
	3	47	13.7	13.7	70.6
	4	35	10.2	10.2	80.8
	5	36	10.5	10.5	91.3
	6	30	8.7	8.7	100.0
	Total	344	100.0	100.0	

Table 4

Discharge Reasons to Permanent Home Placements

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reunified with parent, primary caretaker	117	34.0	34.0	34.0
	Living with other relative(s)	13	3.8	3.8	37.8
	Adoption	210	61.0	61.0	98.8
	Guardianship	4	1.2	1.2	100.0
	Total	344	100.0	100.0	

Table 5

Race and Ethnicity by Age of Child at the End of FFY

Derived Race and Ethnicity	Age of Child							
	0	1	2	3	4	5	6	Total
Non-Hispanic (NH), White	17	57	52	23	17	23	18	207
NH, Black	5	14	23	13	6	7	7	75
NH, Am Ind AK Native	0	0	0	0	0	0	1	1
NH, Asian	2	1	1	1	0	0	0	5
NH, more than One Race	1	3	2	3	1	2	1	13
Hispanic (Any Race)	2	6	5	7	10	3	3	36
Race/Ethnicity Unknown	2	1	2	0	1	1	0	7
Total	29	82	85	47	35	36	30	344

Table 6

Length (Days) in Current Placement Setting by Diagnosed Disabilities

		Length (days) in Current Placement Setting	Mental Retardation	Visually or Hearing Impaired	Physically Disabled	Emotionally Disturbed	Other Diagnosed Condition
N	Valid	343	344	344	344	344	344
	Missing	1	0	0	0	0	0
M		424.76	.04	.03	.21	.12	.68
	SD	332.599	.198	.168	.409	.324	.466
	Variance	110622.280	.039	.028	.168	.105	.217

Table 7

Child Sex, Race, and Ethnicity by Length (Days) in Current Placement Setting

Race and Ethnicity			Length (days) in Current Placement Setting *M*
Non-Hispanic (NH), White	Child Sex	Male	390
		Female	452
NH, Black	Child Sex	Male	435
		Female	416
NH, Am Ind AK Native	Child Sex	Male	.
		Female	525
NH, Asian	Child Sex	Male	224
		Female	611
NH, Hawaiian /Hawaiian /another Pac Islander	Child Sex	Male	.
		Female	.
NH, more than One Race	Child Sex	Male	536
		Female	227
Hispanic (Any Race)	Child Sex	Male	505
		Female	499
Race/Ethnicity Unknown	Child Sex	Male	197
		Female	330

Note. N =343

Table 8

Diagnosed Disabilities by Case Diagnosis Type

		Case Disability Type Totals		
		1.00	2.00	3.00
Mental retardation	Yes	8	5	1
Visually or hearing impaired	Yes	6	4	0
Physically disabled	Yes	62	10	1
Emotionally disturbed	Yes	29	12	0
Other diagnosed condition	Yes	210	23	1
Totals		315	27	1

Note. N =343

Table 9

Length (Days) of Stay in Current Placement Setting by Child Sex and Discharge Reasons

Child Sex	Discharge Reason	*M*	*SD*	*N*
Male	Reunified with parent, primary caretaker	128.37	164.511	68
	Living with other relative(s)	118.33	134.655	6
	Adoption	582.13	300.746	118
	Guardianship	506.50	328.023	4
	Total	408.96	337.762	196
Female	Reunified with parent, primary caretaker	170.58	164.573	48
	Living with other relative(s)	119.57	211.141	7
	Adoption	614.27	276.159	92
	Total	445.84	325.538	147
Total	Reunified with parent, primary caretaker	145.84	165.145	116
	Living with other relative(s)	119.00	172.759	13
	Adoption	596.21	289.991	210
	Guardianship	506.50	328.023	4
	Total	424.76	332.599	343

Note. N =343

Results

Table 1, descriptive analysis, identified (*N*=344) children with a clinically diagnosed disability. Within the sample, children with other diagnosed conditions (*n* = 235) represents the largest group with a clinically diagnosed disability (*M* = 0.68, *s* = 0.466) of children. The count of race and ethnicity by gender in Table 2, shows a larger proportion of male children 197 (57.3%) compared to females 147 (42.7%) and non-Hispanic Whites children were the largest of the racial and ethnic groups 207 (60.2%) in the sample population. The race and ethnicity sample had 60% non-Hispanic White, 21.8% non-Hispanic Black, <1% non-Hispanic American Indian/Alaskan Native, <1% non-Hispanic Asian, <1% as more than one race, 10.5% Hispanic (any race), and 2% race and ethnicity unknown. Table 3 distribution of children aged 0 to 6 at the end of FFY 2012 or at exit from care, showed that more than 48% of children who left care were between 1 to 2 years of age. The analysis of discharge reasons for children to permanent placements had 61% adopted, 34% reunified with parent or primary caretaker, 3.8% living with other relative(s), and 1.2% discharged to a guardian (Table 4).

Table 5 assessed the relationship between race and ethnicity by the age of child at the end of FFY. The analysis found that non-Hispanic Whites 207 (60.2%) and children aged 1 to 2 years 176 (48.5%) were the highest proportion of children served by race and ethnicity and for children aged 0 to 6 years. Table 6, analysis of length of stay (in days) in current placement setting by diagnosed disability had one missing case. The sample population (*N* =343), had an averaged (*M* = 424.76, *s* = 332.599) stay in care. There are noticeable differences found such as children with other diagnosed conditions had the highest mean length of stay that averaged 289 days (*M* = 0.68, *s* = 0.466). Comparing these children to the next order of stay, those who were physically disabled had an average stay of 89 days (*M* = 0.21, *s* = 0.409). Children who were emotionally disturbed averaged a stay of 50 days (*M* = 0.12, *s*= 0.324). Children with visually or hearing impaired and mental retardation had a shorter stay that averaged 17 days (*M* = 0.03, *s* = 0.168) and 17 days (*M*= 0.04, *s* = 0.198), in that order.

Table 7 examined child sex, race and ethnicity with the (LOS) in current placement setting. The sample population (*N* =343), had an average stay of 5,347 days. Male children had a shorter stay that averaged 2,287 (43%) days compared to females averaging 3,060 (57%) of the total days. Hispanic (any race) averaged the longest stay at 1,004 days; Non-Hispanic Blacks averaged a stay at 851 days, and non-Hispanic Whites averaged 842 a stay of days. Children whose race and ethnicity were unknown had the shortest length of stay at their placement setting.

Table 8 results of children with diagnosed disability by case disability types showed the category of children with other diagnosed conditions had (234) 68% cases that were disproportionally higher than all case diagnosis types. Within the sample of children with Clinically Diagnosed Conditions, (315) 92% had a single diagnosis. Table 9 analyzed the length (in days) of stay in current placement setting by gender, and discharge reason. The population sample (*N* =343), averaged (*M* = 424.76, *s* =332.599) days stay for Pennsylvania's children in foster care. Male (*n*=196) children had a shorter mean stay that averaged (*M* = 408.96, *s* = 337.762) days, when compared to females (*n*=147) who averaged (*M* = 445.84, *s* = 325.538) days. The children being adopted (n =

210) averaged the longest stay (*M* = 596.21) days, followed by those discharge reason to guardianship (*M* = 506.50) days, reunified with parent or caregiver (*M* = 145.84) days, and living with other relatives (*M* = 119) days.

Statistical Assumptions in Study

To test the statistical assumptions in the study, a paired samples *t*-test was used to test the differences, if any, that may exist between the means of the samples. As the dependent and independent samples were collected from the same individuals, a paired-samples *t*-test was the appropriate test that paired of individuals for analysis of significance (IBM Corporation SPSS Statistics Part 2, 2016b). The results compared the means between the dependent variable, discharge reason as permanent home placements (reunified to parents or caregivers, living with relatives, adoption, or guardianship) and the independent variable, diagnosed disability (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions).

Table 10 examined the results of paired samples correlations between diagnosed disability (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions) and discharge reason as permanent home placements. The strength of relationships between the variables was assessed using correlation coefficients that range from –1 to +1. IBM Corporation SPSS Statistics Part 2 (2016b) analysis found a positive correlation for Pair 6 ($r = 0.097$) between other diagnosed condition and discharge reason. Additionally, the US DHHS ACYF Children’s Bureau (2014) cited Guilford (1956) work that “a coefficient of 0.0 up to plus or minus .20 indicates a very low or negligible correlation” (Chapter I, p.4). The remaining paired samples 1 through 5 showed no correlation.

Table 10

Paired-Samples t-*Test Correlations Between Variables*

		N	Correlation	Sig.
Pair 1	Diagnosed disability &Discharge reason	344	.	.
Pair 2	Mental retardation &Discharge reason	344	-.034	.528
Pair 3	Visually or hearing impaired & Discharge reason	344	-.036	.503
Pair 4	Physically disabled & Discharge reason	344	-.024	.660
Pair 5	Emotionally disturbed & Discharge reason	344	-.133	.014
Pair 6	Other diagnosed condition & Discharge reason	344	.097	.072

Statistical Analysis Findings: Research Question and Hypotheses

I used the general linear model (GLM) univariate analysis method to analyze and organize the RQ and hypotheses to determine if an observed differences and statistical significance exist between the means of the paired dependent and the independent variables. The GLM testing method produced the exact statistics and associated values as it examined the relationships between the dependent variable, interactions between variables, the effects of covariates as factors, and covariate interactions with other factors (IBM Corporation SPSS Statistics Part 4, 2016c). The analysis results in Tables 11 and 12, tests of between-subjects effects examined LOS in the current placement setting by other medically diagnosed conditions, as well as LOS in the current placement setting by derived race and ethnicity variable. Table 11 found positive significant effects at (p = 0.019) and at Table 12 (p = .047), respectively, as both was less than the threshold (0.05). Results of other tests of between-subjects effects were analyzed for length of stay in the current placement setting by emotionally disturbed, physically disabled, visually or hearing impaired, mentally retarded, gender, and age; no significant effects was found at (p = .152, p = .099, p =.770, p = .938, p = .314, and p = .000) respectively. Confidence Intervals were at 95% and all were more than the threshold (0.05), except for test between LOS in the current placement setting by age at (p<.01).

Table 11

Tests of Between-Subjects Effects: Length of Stay in Current Placement Setting by Other Medically Diagnosed Conditions

Source	Type III Sum of Squares	*df*	*MS*	*F*	*Sig.*
Corrected model	130.319[a]	2	65.160	111.372	.000
Intercept	274.240	1	274.240	468.733	.000
Setting LOS	127.011	1	127.011	217.088	.000
Other medically diagnosed condition	3.233	1	3.233	5.526	.019
Error	198.923	340	.585		
Total	2158.000	343			
Corrected total	329.242	342			

Note. a. R Squared = .396 (Adjusted R Squared = .392); *MS* = mean square

Table 12

Tests of Between-Subjects Effects: Length of Stay in Current Placement Setting by Race and Ethnicity

Source	Type III Sum of Squares	*df*	*MS*	*F*	Sig.
Corrected model	133.712[a]	6	22.285	38.295	.000
Intercept	56.118	1	56.118	96.434	.000
Setting LOS	125.269	1	125.269	215.264	.000
Race	6.626	5	1.325	2.277	.047
Error	195.530	336	.582		
Total	2158.000	343			
Corrected total	329.242	342			

Note. a. R Squared = .406 (Adjusted R Squared = .396); *MS* = mean square

IBM Corporation SPSS Statistics Part 2 (2016b) paired-samples *t*-test method computed the statistics and associated probability values between the dependent and the independent variables shown in Table 13. The paired samples compared the means of discharge reason and diagnosed disability. The variables shared related data and the analysis had mean paired differences of 1.31 to 2.28. Table 13 used univariate descriptive statistics to examine paired samples (mean, sample size, standard deviation, and standard error). IBM Corporation SPSS Statistics Part 2 paired-multiple samples to determine whether mean differences exist between the dependent and the independent variables were significantly different. On average, the dependent variable (discharge reason) mean scores were higher than the independent variable (diagnosed disabilities) scores.

Table 13

Paired Samples t-Test Statistics Between Variables

		M	*N*	*SD*	*SE*
Pair 1	Diagnosed disability	1.00	344	.000	.000
	Discharge reason	2.31	344	.982	.053
Pair 2	Mental retardation	.04	344	.198	.011
	Discharge reason	2.31	344	.982	.053
Pair 3	Visually or hearing impaired–Discharge	.03	344	.168	.009
	Reason	2.31	344	.982	.053
Pair 4	Physically disabled	.21	344	.409	.022
	Discharge reason	2.31	344	.982	.053
Pair 5	Emotionally disturbed	.12	344	.324	.017
	Discharge reason	2.31	344	.982	.053
Pair 6	Other diagnosed condition	.68	344	.466	.025
	Discharge reason	2.31	344	.982	.053

Note. *SE* = Standard error

The analysis of Table 14paired-samples *t*-test differences between variables found that the independent variable contained several factors and required paired samples for analysis. For this reason, diagnosed disabilities (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions) and discharge reason as permanent home placements were paired for analysis. Based on IBM Corporation SPSS Statistics Part 2 (2016b) formula, Pair 1 to 6 observed mean differences are -1.305, -2.265, -2.276, -2.093, -2.186, and -1.622. The *t*-test values = -24.645, -41.643, -42.108, -36.173, -37.730, and -28.778, and all are at $p<0.05$ (Table15). The observed mean differences between the factors of diagnosed disabilities and permanent home placements appear to have some statistically significant among Pairs 1 to 6 and the hypothesis to be rejected.

Table 14

Paired-Samples t-Test Differences Between Variables

		Paired Differences							
					95% Confidence Interval of the Difference				
		M	*SD*	*SEM*	Lower	Upper	*T*	*df*	Sig. (2-tailed)
Pair1	Diagnosed disability - Discharge reason	-1.305	.982	.053	-1.409	-1.201	-24.645	343	.000
Pair 2	Mental retardation - Discharge reason	-2.265	1.009	.054	-2.371	-2.158	-41.643	343	.000
Pair3	Visually or hearing impaired - Discharge Reason	-2.276	1.003	.054	-2.382	-2.170	-42.108	343	.000
Pair 4	Physically disabled - Discharge reason	-2.093	1.073	.058	-2.207	-1.979	-36.173	343	.000
Pair5	Emotionally disturbed - Discharge reason	-2.186	1.075	.058	-2.300	-2.072	-37.730	343	.000
Pair6	Other diagnosed condition - Discharge	-1.622	1.045	.056	-1.733	-1.511	-28.778	343	.000

Note. *SEM* = Standard mean error; *t*=t-test

Table 15

Correlation Between Variables

		Discharge Reason	Mental Retardation	Visually or Hearing Impaired	Physically Disabled	Emotionally Disturbed	Other Diagnosed Condition
Discharge reason	Pearson Correlation	1	-.034	-.036	-.024	-.133*	.097
	Sig. (2-tailed)		.528	.503	.660	.014	.072
	N	344	344	344	344	344	344
Mental retardation	Pearson Correlation	-.034	1	-.036	-.035	.015	-.208**
	Sig. (2-tailed)	.528		.510	.518	.781	.000
	N	344	344	344	344	344	344
Visually or hearing impaired	Pearson Correlation	-.036	-.036	1	-.047	-.064	-.142**
	Sig. (2-tailed)	.503	.510		.380	.239	.008
	N	344	344	344	344	344	344
Physically disabled	Pearson Correlation	-.024	-.035	-.047	1	-.191**	-.625**
	Sig. (2-tailed)	.660	.518	.380		.000	.000
	N	344	344	344	344	344	344
Emotionally disturbed	Pearson Correlation	-.133*	.015	-.064	-.191**	1	-.347**
	Sig. (2-tailed)	.014	.781	.239	.000		.000
	N	344	344	344	344	344	344
Other diagnosed condition	Pearson Correlation	.097	-.208**	-.142**	-.625**	-.347**	1
	Sig. (2-tailed)	.072	.000	.008	.000	.000	
	N	344	344	344	344	344	344

Note. *. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

The results of bivariate correlation testing are shown in Table 15 that measured the strength or degree of association between the dependent and the independent variables. The IBM Corporation SPSS Statistics Part 2 (2016b) test of significance tested whether observed differences between permanent home placements as discharge reason and the factors for diagnosed disabilities (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions) results occurred because of sampling error or chance. A positive correlation is found between discharge reason and the diagnosed disability factor for other diagnosed conditions. The correlation index for degree of association between the variables is 0.025 (0.097-0.072) that is very low, and is statistically significant at the 0.05 levels (2-tailed). Therefore, testing for the null hypothesis is rejected and the alternative hypothesis is accepted. Meaning that as there is statistically significant association that children with diagnosed disabilities, specifically for other diagnosed condition, that have on home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. A negative correlation is seen in Table 16 between discharge reason and diagnosed disabilities for mental retardation, visual or hearing impairment, physical disability, and emotional disturbance.

Muijs (2011) wrote that effect size tells the statistical significance and strength of the relationship between variables. IBM SPSS Statistics 23 Part 4 (2016c) one-way analysis of variance analyzed factors of the independent dependent to determine the effects on the dependent variable. All the factors of diagnosed disability as the independent variable (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions) were tested with the dependent variable as permanent home placements to assess the measure of statistical significance and strength of the relationship that may exist. The five factors of diagnosed disability did not exhibit the same kind of statistical significance or strength in their relationships. As shown in Table 15, a positive correlation is seen between discharge reason and other diagnosed condition, a factor of diagnosed disability and this relationship is statistically significant. This allows the null hypothesis to be rejected and the alternative hypothesis accepted due to the statistically significant association between the variables. The strength of the correlation is very low on a scatter plot, as the line of fit is at (r = 0. 025). The line of fit is a numerical index between 0 and 1. The correlation index is weak as the data point is at (r = 0. 025).

Results of Post-Hoc Analyses of Statistical Tests

Post-hoc analyses tests for the null hypothesis indicates there is no statistically significant impact that children with diagnosed disabilities have on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. Findings in Tables 1-6 corroborate the results in Table 14, showing that some observed mean differences exist between the variable and with some statistically significant and multiple degrees of the relationships to reject null hypothesis and to accept the alternative hypothesis.

Additional Statistical Tests of Hypotheses

Additional statistical tests of hypotheses have emerged from the analysis of main hypotheses with further insights about the study cohort. The IBM's Corporation SPSS Statistics 23 Part 4 (2016c) GML univariate analysis of variance tested profile plots that compared the marginal means and examined the relationship between the dependent and the independent variables, and the factors specified as covariates. The dependent and the independent variables failed to produce a single means plots, as results indicate no statistics was computed due to fewer than two groups for the dependent variable as discharge reason. Nevertheless, other estimated marginal means and profile plots below show results of data analyzed in this study in Figures 3 through 10.

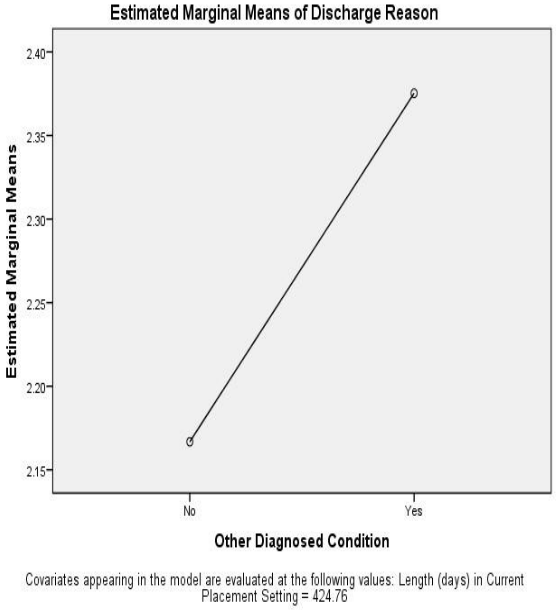

Figure 3. Plot for paired sample *t*-test differences between by discharge reason and other diagnosed conditions (see Table10, 14)

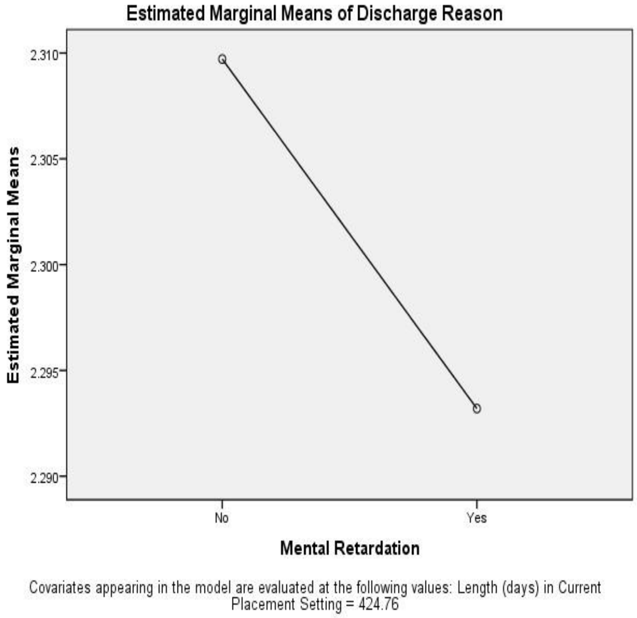

Figure 4. Plot for paired samples *t*-test discharge reason by mental retardation (see Table 14)

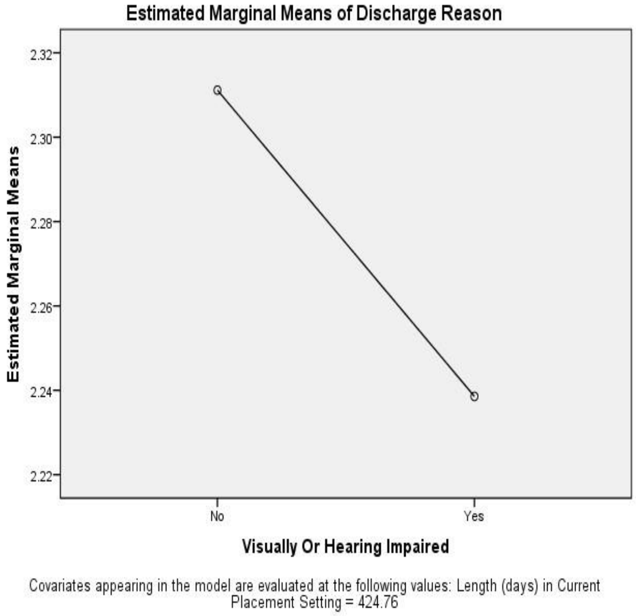

Figure 5. Plot for paired samples *t*-test, discharge reason by visual or hearing impaired (see Table 14)

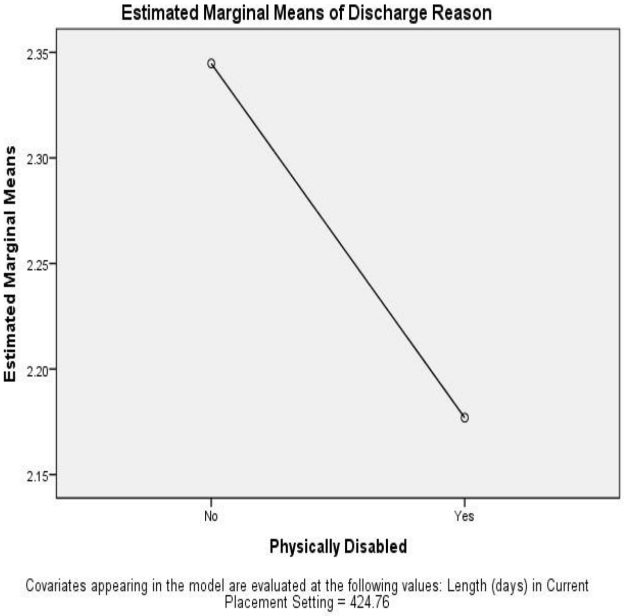

Figure 6. Plot for paired samples *t*-test discharge reason by physical disability (see Table 14)

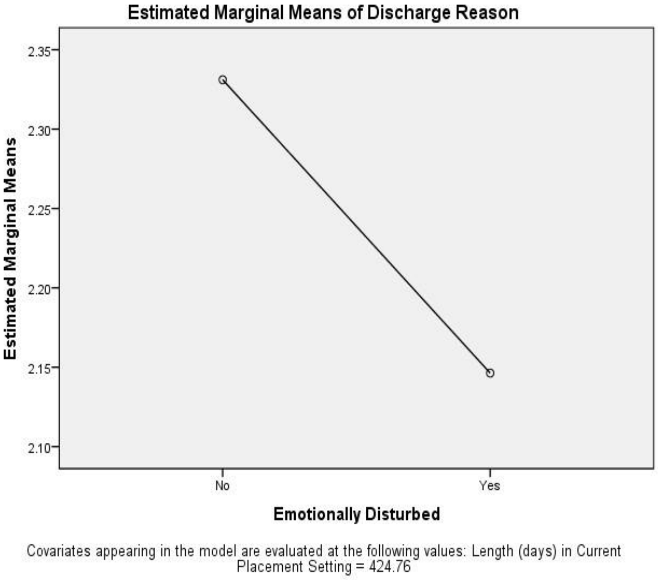

Figure 7. Plot for paired samples *t*-test, discharge reason by emotional disturbance (see Table 14)

Figure 3 analysis results from Tables 14 and 15, paired sample *t*-test differences and correlations between the variables. The dependent variable as discharge reasons and factors of independent variable as diagnosed disabilities include (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions). The results of the Figure 3 plot found that discharge reason had positive significant effects on other medically diagnosed conditions. The plots for Figures 4 to 7 are the results from Tables 14, paired- samples *t*-test differences between variables found no positive significant effects.

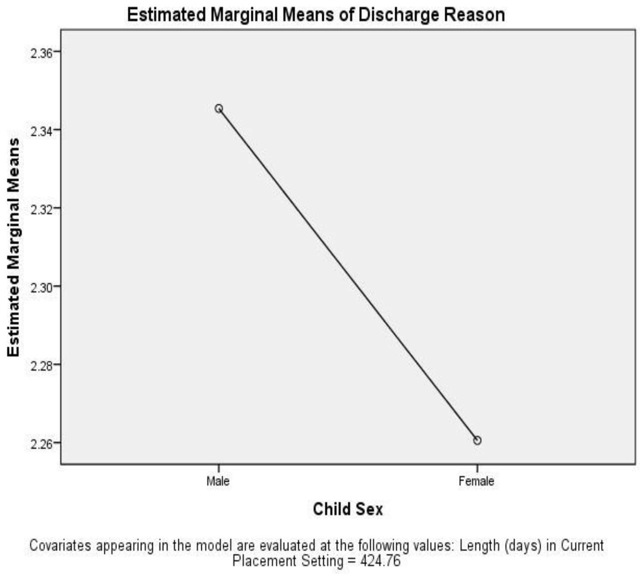

Figure 8. Plot for paired samples *t*-test, discharge reason by child sex (see Table 9)

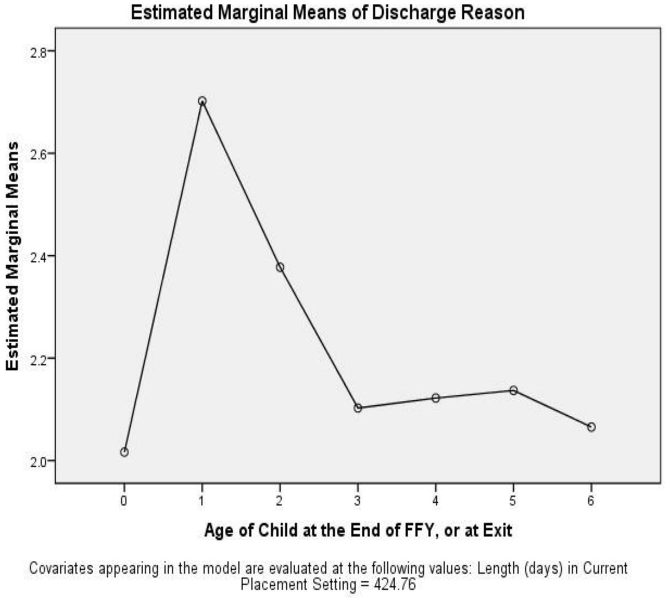

Figure 9. Plot for paired samples *t*-test, discharge reason by age of child at end (see Table 3 and 5)

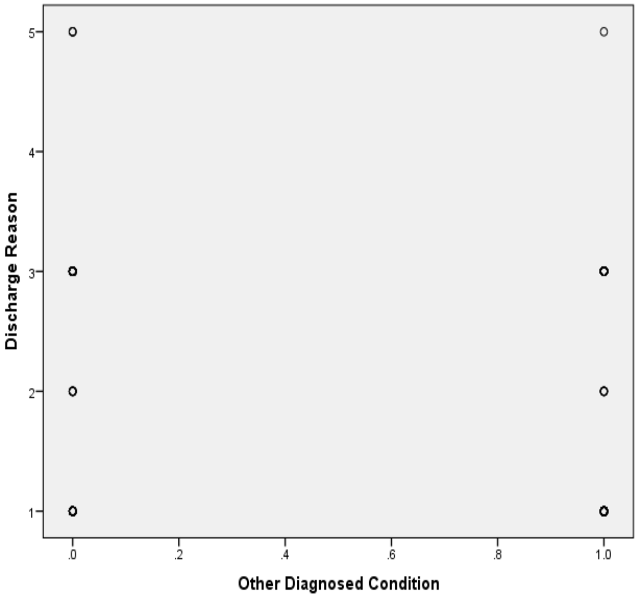

Figure 10. Graph of scatterplot correlation discharge reason by other diagnosed conditions (see Table 15)

The plot for Figure 8 analysis results from Tables 9, examined length of stay in the current placement setting by gender, and discharge reason found no significant effects on gender. The analysis of data from Table 9 found that female children had a longer stay in care than male children. Also, that children being adopted had the longest stay in care. In Figure 9 results from Tables 3 and 5, showed that length of stay in the current placement setting by age had positive significant effects for the sample of younger children having a shorter stay in care. Among these children who were discharged, children who were between 1 to 2 years of age left foster care sooner than the older children at age 6. Figure 10 graph of scatterplot tested the correlation between variables (Table 15) and found a positive correlation between discharge reason and other diagnosed condition, a factor of diagnosed disability. There is statistically significant relationship with a very low correlation index at (r = 0. 025), as the data points lie away from the line of fit.

Summary

In Chapter 4 the results displayed quantitative findings of the demographic characteristics about the sample population and RQ on what impact, if any, children with diagnosed disabilities had on permanent home placements among Pennsylvania’s foster care children who were discharged and were between the ages of 0 to 6 years in 2012. Analysis of the predefined sample of children in foster care has similarities that paralleled with the population of interest for a study. The data analysis results inferred that statistically significant relationship did exist and that the dependent variable (permanent home placement) have an impact on the independent variable (diagnosed disabilities), among foster care children with other diagnosed conditions who were discharged and were between the ages of 0 to 6 years in 2012. Evidence from these findings are presented in Chapter 5 to show implications of positive social change of these conclusions, along with discussions that summarized and interpreted key findings, limitations, recommendations, and implications for further research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to determine whether standards established for Pennsylvania in 1982 identified evidence of whether state licensing code policies were able to determine the relationships that diagnosed disabilities have on and permanent placements. To assess this impact, I used a nonexperimental quantitative approach to examine and describe AFCARS data for an in-depth understanding of the effect that the independent, dependent, and covariate variables had on Pennsylvania's children in foster care. A retrospective design was used to collect federal archived data, and bivariate analysis results described relevant features of the data without manipulation or random assignments. I conducted the study to inform ways to advance strategies that increased placement stability for children with diagnosed disabilities who are in foster care.

Pennsylvania ranked fifth in the nation among the population of children, (n = 23,523) or 3.7%, served in FFY 2012. My analysis of population data identified a predefined sample group of children, (N =344) or1.46%, in foster care with a clinically-diagnosed disability who were aged 0 to 6 years and were discharged to a permanent home placement for this study. A key finding of the hypothesis testing showed that there was a statistically significant relationship that children with diagnosed disabilities had on home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. I conducted paired samples t-tests compared the means of the dependent variable discharge reason as permanent home placements (reunified to parents or caregivers, living with relatives, adoption, or guardianship) and the independent variable diagnosed disability (mental retardation, visual or hearing impairment, physical disability, emotional disturbance, or other medically diagnosed conditions). Observed mean differences were identified at $p<0.05$ for the factors as Pair 1 through 6 (Table 13).

The findings of statistical significance from the data analyzed correlated to the literature reviewed (Stalker & McArthur, 2012; Task Force on Health Care for Children in Foster Care, 2005; US DHHS ACYF Children's Bureau, 2014). The population of foster care children showed a statistically significant association that children with diagnosed disabilities had on home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. As a result, this could present a need to identify and recommend improved coordination of services for children in foster care.

Interpretation of the Findings

Findings Confirm, Disconfirm, and Extend Knowledge

For this study, I examined case files data (N =344) to describe the impact that children with diagnosed disabilities had on permanent home placements among the foster care children who were discharged and were between the ages of 0 to 6 years in 2012. The analysis I conducted and shown in Table 3 found that a higher proportion of male children 196 (57%) were served in my sample than female children 147 (43%) were served in foster care. Also, the data for non-Hispanic White children 207 (60%) and non-Hispanic White male children 120 (58%) represented the largest race, ethnicity, and gender within the sample. This finding disconfirmed the peer reviewed literature described in Chapter 2 that identified non-Hispanic Blacks as being disproportionately represented among the racial and ethnic groups in foster care (National Council of Juvenile and Family Court Judges, 2013). Instead, Table 3 showed non-Hispanic Blacks 75 (21.8%) ranked second, followed by Hispanics children (any race) 36 (10.5%) who were disproportionately served (see National Council of Juvenile and Family Court Judges, 2013).

Scientific findings confirmed in the peer-reviewed literature added that decreasing disparities can improve health outcomes across these population groups (US DHHS HRSA MCHB, 2010). In the analysis of data shown in Table 6, I found that noticeable differences exist between LOS in current placement setting for children with diagnosed disabilities who had an average stay of 424.76 days. Further results in Table 6 indicated that children with other diagnosed conditions stayed an averaged (M = 0.68) 289 days, the longest stay in care. A comparison with children who were physical disabled, emotionally disturbed, mental retardation, and visually or hearing impaired had significantly shorter stays in foster care. Based on the AFCARS (2012) report, the children with other diagnosed conditions have chronic medical conditions that can extend their stay in foster care. This finding disconfirmed the peer-reviewed literature described in Chapter 2 (see Child Welfare Information Gateway, 2012a; Powers et al., 2012; Stalker & McArthur, 2012; Task Force on Health Care for Children in Foster Care, 2005; US DHHS ACYF Children's Bureau, 2014) that discussed diagnosed disabilities, rather than individual factors. The absence of this evidence to extend knowledge in the discipline is an opportunity for future research.

In Table 8, the findings for the length of stay (in days) in current placement setting for children with a diagnosed disability has confirmed knowledge in the discipline as the peer-reviewed literature described in Chapter 2. Findings in the literature review noted that children with disabilities were more predisposed to persistent health conditions and had a lesser chance for timely placements (see Stalker & McArthur, 2012; Task Force on Health Care for Children in Foster Care, 2005). My analysis also extended knowledge in the discipline as it found co-occurrences of multiple disorders as 315 (92%) children had a single case disability type, especially for those children with other clinically diagnosed conditions who had a longer stay in care; 27 (8%) cases had two disability types, and a single child has three disability types. There were 23 (85%) children with dual disability types, primarily for other diagnosed conditions. Stokols' (1996) social ecological theory placed emphasis on the cumulative effect of multiple diagnosed conditions, while AFCARS's (2012) technical bulletin report added that children with other diagnosed conditions had chronic medical conditions that may have extended their stay in foster care. The co-occurrences of multiple disorders among children with other diagnosed conditions extend knowledge in the discipline on the importance of having a timely plan for a permanent living arrangement (Powers et al., 2012; Stalker & McArthur, 2012; US DHHS ACYF Children's Bureau, 2012e).

According to the US DHHS ACYF Children's Bureau (2014), the contents of Table 7 are among the covariates of interest to complement the dependent variable in this study. My analysis of gender, race, and ethnicity by length (in days) of stay in current placement setting found that Hispanics (any race) had the longest stay, which averaged

1,004 days, followed by non-Hispanic Blacks who averaged 851 days, non-Hispanic Whites who averaged 842 days, and children with unknown race and ethnicity had the shortest averaged stay of 527 days. The covariates of interest filled a gap in the literature and extended knowledge in the discipline about Hispanic (any race) children's length of stay in foster care.

For the length (in days) of stay in placement by gender and discharge reason, Table 10 contains the findings that disconfirmed knowledge in the discipline by showing that male children had a shorter stay in foster care than female children. Among discharge reasons, the results disconfirmed knowledge in the discipline as 13 (M = 119) children had the earliest discharge to living with other relatives, followed by 116 (M =145.84) children reunified with a parent or primary caretaker, followed by guardianship and adoption. Finally, the children who were being adopted, n = 210 or 61%, had a longer stay in care and male children had a shorter discharge time than the female children in care; these findings have extended knowledge in the discipline.

Findings in the Context of the Theoretical Framework

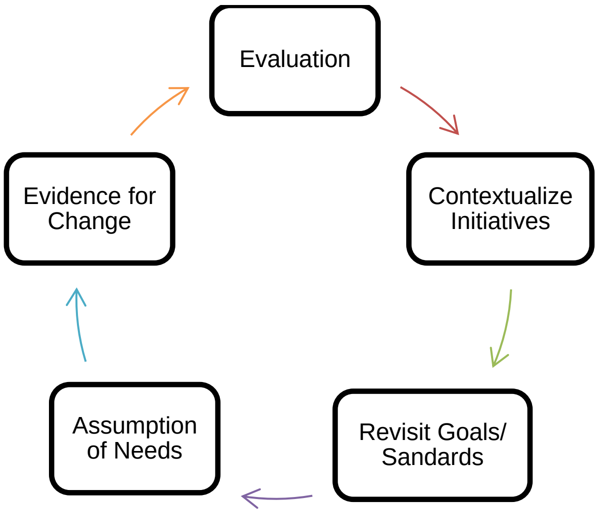

Figure 11. Contextual framework for theories in this study.

Hernandez and Hodges's (2006) theory of change and Stokols' (1996) social ecological theory were the theoretical framework for this study. These theories highlighted logical connections for the commonwealth of Pennsylvania standards to authorize the licensed foster care placement agencies, evidence based indicators in use, and strategies intended to achieve those results. Taplin's et al. (2013) added a pathway for using the theory of change (see Figure 11 above). The illustration in Figure 11 offers ways that the commonwealth of Pennsylvania can: (a) evaluate the 1982 standards that authorize the licensing of foster care agencies; (b) contextualize initiatives to help understand expectations that are expected; (c) revisit standards and challenges of existing state practice; (d) make assumptions on whether standards can increase permanent home placements for children with diagnosed disabilities in foster care; and (e) if standards are outdated or expectations are not met, identify evidence for change to achieve the intended goal.

Hernandez and Hodges's (2006) theory of change offers an ongoing process for planning, organizing, and bringing "consensus among interagency partners and other stakeholders for a shared overall service delivery strategy" (p. 172). Considering the research findings, the theoretical context requires an interagency collaboration of critical stakeholders, such as education, juvenile justice, law enforcement, mental health, and public health, for coordinating and integrating serves to children whose needs cross multiple systems. This collaborative undertaking responds to the evidence that showed this age group of children in this study was more vulnerable to adverse health and social factors (see Federal Interagency Forum on Child and Family Statistics, 2012; Task Force on Health Care for Children in Foster Care, 2005). The AFCARS (2016) offered a similar approach to organize service planning through a federally-mandated data collection system that collects case specific information to link indicators of success.

Hernandez and Hodges's (2006) theory of change offered a mechanism to bring together collaboration and consensus among its partners and stakeholders to help improve service delivery. This service delivery model can offer ways for Pennsylvania's child welfare system that is state-supervised and county-administered, to incorporate evidenced based standards for licensing foster care agencies across its 67 counties (Child Welfare Information ay, 2012b; Hernandez & Hodges, 2006). Pennsylvania Department of Human Services (Pennsylvania DHS, 2016) noted in its *2016 Child Protective Services*

Report that the office has administrative oversight for the licensing of public and private child welfare agencies and investigation of complaints regarding these agencies. Within a theory of change framework, the Pennsylvania's DHS collaborates with regional Offices of Children, Youth, and Families to oversee and enforce state and federal laws, regulations, and policies for the 67 child welfare services counties (Pennsylvania DHS, 2016).

Stokols' (1996) social ecological theory defined a set of theories for behavioral changes and environmental factors that can be used to improve health. Considering the research findings, this theoretical context would be best used as an interdisciplinary prevention framework to improve individual's health among child welfare systems, community participation, and public policies over time. It appears that the social ecological theory was used by child welfare agencies across the United States to build infrastructures support systems of care to intervene effectively in the lives of children and their families. Moreover, the US DHHS ACYF Children's Bureau (2014) reported that AFCARS data collection systems were in place for states, federal departments, and researchers to develop policies and address program management issues that can address the impact that children with diagnosed disabilities had on permanent home placements among the states foster care children who were discharged and were between the ages of 0 to 6 years in 2012. The policies of the US DHHS ACYF Children's Bureau defined the pathway for standards used to increase permanent home placements for children with diagnosed disabilities who are in foster care.

Limitations of the Study

Federal child welfare outcomes data estimates in Chapter 1 underreported the services that were provided to foster care children statewide in FFY 2012. The receipt of updated data files from NDACAN showed that more children in foster care had received services than estimated in the FFY. These updated files were used to purposively extract data for children served statewide, in foster homes, between aged 0 to 6 years, discharged to placements, and had characteristics of clinically diagnosed disabilities for the study sample. A limitation may have occurred in this study as the AFCARS data files from NDACAN did not contain date-related covariates proposed for extraction. Nevertheless, the date-related covariates were omitted and replaced with the LOS in current placement setting that confirmed and extended knowledge in the discipline.

The sampling approach may have contributed a methodological limitation for this study as no control, manipulation or altering of the variables occurred, but instead, the study relied on interpretation of the secondary analysis to develop a conclusion without demonstrating a cause-and-effect relationship (Belli, 2009; McNabb, 2008). The study intent is to use nonexperimental quantitative method supported by Belli’s (2009) design to retrospectively describe archived data, measure variables as they exist at that time, without manipulation or generalizing results of causality to the population, and based conditions that were present in a single point in time. McNabb’s (2008) method supports purposive sampling, as a non-probability method to identify data for a predefined group in a study. While obvious advantages exist to analyze archived data, Cheng and Phillips (2014) wrote that these data were not collected to address researcher’s RQ or hypothesis, as in the case for this study. An added constraints and biases may exist from the way that child welfare services were operated and delivered to ensure compliance to federal mandates. The Child Welfare Information Gateway (2012b) reported that the centralized administrative system to collect child welfare data for this state were not yet in place; however, US DHHS ACYF Children's Bureau (2012c) reported that this centralized administrative system and other enhancements were being implemented.

The external validity to establish trustworthiness of the population data may be in question for this research use of archived data that was collected by multiple foster care agencies and reported to NDACAN (Child Welfare Information Gateway, 2012b). Hence, the data files and records could be collected with a biased on how questions were administered to parents. There are no threats to internal validity in this study, as the data files were only used to analyze and report the dependent and the independent variables collected from historical records. Gravetter and Forzano's (2012) supported the use of nonexperimental studies to answer questions about groups or about whether group differences existed. Therefore, statistical conclusions from the analysis of archived data files are not considered threats to reliability or validity.

Recommendations

The study results contributed to understanding the impact that diagnosed disabilities have on permanent home placements among Pennsylvania's foster care children who were discharged and were between the ages of 0 to 6 years in 2012. The findings identified connections from the commonwealth of Pennsylvania standards to authorize the license foster care placement agencies, evidence-based indicators in use, and strategies intended to achieve those results. The AFCARS Foster Care File from the NDACAN provides a significant source of archived data for secondary analysis, with ongoing technical support and monitoring to address states' data limitations prior to its publication (AFCARS, 2012; US DHHS ACYF Children's Bureau, 2014). As the Child Welfare Information Gateway (2012b) added, having a centralized administrative system for collecting child welfare data for state may alleviate discrepancies that are present. The AFCARS Foster Care Files used in this study were distributed annually across Federal agencies, states, and research communities, as the Children's Bureau encouraged there use for further analysis (AFCARS, 2016).

Recommendations for further research that are grounded in the strengths and limitations of the current study should consider foster care files as comprehensive and reliable source of data to address national and states performance outcomes in child welfare programs. The AFCARS data collection system does provide uniform definitions, methodologies, and data standards to generate specific objectives that are considered reliable and consistent. It is also noteworthy to mention that the study boundaries were limited to the sample size; therefore, differences should be interpreted with caution as patterns of results could shift with the use of a larger data sample.

The literature reviewed in Chapter 2 identified promising strategies on the impact that children with diagnosed disabilities have on permanent home placements, particularly among the population of foster care children who were discharged and were between the ages of 0 to 6 years in 2012. To support the dependent variable as permanent home placements for children in foster care, Bethell's et al. (2011) research encouraged an evaluation of national and state data on the prevalence of health problems and any special health care needs that may exist among children served by the child welfare agencies. This recommendation is supported by findings in the literature review that concluded children in foster care with disabilities had less successful placements that those without (Bethell et al., 2011; Jaudes et al., 2012; Sege, 2010; Task Force on Health Care for Children in Foster Care, 2005; US DHHS ACYF Children's Bureau, 2014). These researchers point of view were supported by results of this study that suggests some noticeable differences exist, between length (in days) of stay in current placement setting by permanent home placements, diagnosed disabilities, gender, and race and ethnicity.

The Healthy People 2020 (2010) national objectives aimed to improve the well-being of infants, children, and families and are an important public health goal for the United States. As these objectives include data that pertains to disability and health, Brault (2012) reported that "approximately 56.7 million people (18.7 percent) of the 303.9 million in the civilian no institutionalized population had a disability in 2010" (p.73). The findings from this study and the literature described in Chapter 2, supported the Healthy People 2020 objectives that identified race, ethnicity, gender, length (days) of stay in placement setting, discharge reasons, and co-occurrence of multiple disorders were among the important factors that can affect timely permanency placements and the well-being of children (Child Welfare Information Gateway, 2012a; Healthy People 2010, 2020; National Council of Juvenile and Family Court Judges, 2013; Powers et al., 2012; Stalker & McArthur, 2012;Task Force on Health Care for Children in Foster Care, 2005; US DHHS ACYF Children’s Bureau, 2014).

Based on the RQ to assess the impact that diagnosed disabilities have on home placements for children in foster care, the findings from this research supports existing national policy recommendations that guide improvements for child welfare practices. The recommendation is based on the Child Welfare Information Gateway (2012a) report that states were responsibility for child welfare services to address the needs of children and families; however, the funding eligibility required states to comply with specific federal policies and guidelines for delivering programs. The US DHHS ACYF Children’s Bureau (2012c) wrote that child welfare professionals should seek out opportunities to promote the social and emotional well-being for children and families. The Administration encouraged service professionals to (a) to have a trained workforce to meet the needs of children and families, (b) provide support to strengthens the environments and build relationships for children and families, and (c) increase access to screening and assessment tools that provides effective evidence based interventions. Demonstration projects are in place for states child welfare agencies to expand their service to include trauma-focused care (US DHHS ACYF Children’s Bureau, 2012c). This appears to be an advantage for foster care administrations to consider while improving the well-being of children, youth, and families.

As children in foster care are in the custody of their state, a recommendation for the commonwealth of Pennsylvania’s Code that governs the licensing of foster care agencies is to institute policies that assess the health and social needs of children in their care. Simms et al. (2002) emphasized that children should have a medical home that provides preventive health services to appropriately treat acute and chronic problems. Furthermore that “the effectiveness of coordinated primary health care services may be reflected in reduced reliance on inappropriate emergency department visits, subspecialist consultations, and laboratory investigations” (Simms et al., 2000, p. 916). While it is important to have primary care services in place, Simms et al. added that primary care providers should communicate with other professionals to develop a comprehensive plan for the care of children in foster care. Fang et al. (2012) noted that some states may have the flexibility to provide Medicaid coverage to children in foster care. Fang et al. added that the Medicaid eligibility rules in Pennsylvania allow child protective service to conduct investigation for children in foster care, and does permit communication with other professionals to provide timely medical and mental health services to improve care.

These recommendations and findings from the demonstration projects are expected to identify interventions to increase further opportunities to achieve timely permanent placements stability for children with diagnosed disabilities. The US DHHS ACYF Children’s Bureau (2012c) reported that Pennsylvania’s largest county human services agencies, were to “develop a new case practice model focused on family engagement, assessment and the introduction or expanded use of evidence-based practices” (p. 20). The project is expected to aid the work of providers who are serving children in, or at-risk of entering placement, discharged from placement, or receiving in-home services.

Implications for Positive Social Change

There is broad support throughout this research to gather evidence to inform decision-making, support policies, and increase the momentum for continuous quality improvement within the child welfare system. To address the problem, this study gathered evidence to suggest that the state needed to have initiatives in place to increase permanent home placement for children in foster care who had a diagnosed disability (Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition, 2003; US DHHS ACYF Children's Bureau, 2010a, 2012a, 2012b, 2012c). The Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition (2003) and US DHHS ACYF Children's Bureau (2010a) lead the charge for a positive social change by integrating congressionally mandated child welfare priorities to achieve safety, permanency, and well-being of children and families. The US DHHS ACYF Children's Bureau (2012c) introduced a series of papers on *Integrating Safety, Permanency and Well-Being in Child Welfare*, to enhance a national dialogue among child welfare administrators and researchers working to integrate congressionally mandated goal to advance public policy initiatives for children in foster care.

Promising practices discussed throughout this study has shown the potential impact for positive social change on the RQ that assessed the impact children with diagnosed disabilities have on permanent home placements. Among the series of presentations to the US DHHS ACYF Children's Bureau, Akin, Bryson, McDonald, and Wilson (2014) described a Kansas Intensive Permanency Project (KIPP) case study that successfully improved both child and system level outcomes. Akin, Bryson, et al.

research supports a positive social change for Pennsylvania as the ACYF Children's Bureau framework is empirical evidence that successful attained child welfare outcomes (US DHHS ACYF Children's Bureau, 2012d). Throughout the literature review in Chapter 2 there was support for child welfare administrators to consider evidence based practices to their systems.

Akin, Bryson, et al. (2014) added that service models "are not only supported by empirical research but that also are a good fit with the families to be served, the workforce that will deliver the services, and the community and funding framework in which the services will be delivered" (p. 1). This is important consideration and potentially a positive social change for child welfare administrators to consider at the local and organizational level to improve the outcomes for vulnerable children. The researchers integrated the ACYF Children's Bureau's framework into the KIPP case study to further improve children's social and emotional functioning towards the permanency goals. Their goals were to increase reunification, guardianship, and adoption in a population of children at risk for long-term foster care who had serious emotional disturbance. There were policy changes from the KIPP study such as (a) evidence based intervention that increased parenting capacity and children's social and emotional functioning, (b) valid and reliable assessment tools used with children and families, and (c) continuous monitoring of outcome measurements to track social and emotional developmental of children (Akin, Bryson, et al., 2014).

Implications for positive change are anticipated with the recent Pennsylvania's legislative update, Act 115 of 2016. Act 115 of 2016 amended the states' Child

Protective Services Law and the Juvenile Act “to ensure Pennsylvania’s compliance with specific federal requirements under the Child Abuse Prevention and Treatment Act (CAPTA)” (Pennsylvania DHS, 2016, p. 3). This legislative amendment provides support to my research for commonwealth of Pennsylvania’s Code for Public Welfare Title 55 to amend its 1982 standards. Additionally, Pennsylvania is among the demonstration projects that is testing “a new case practice model focused on family engagement, enhanced assessment, and the introduction or expansion of evidence-based programs” (US DHHS ACYF Children’s Bureau, 2012c, p. 3).

The demonstration project targets “children 0-18 in or at risk of entering foster care with the goals of improving permanency, increasing positive well-being outcomes for children and families, and preventing maltreatment and re-entry of children into foster care” (US DHHS ACYF Children’s Bureau, 2012c, p. 3). The project team has already identified several standardized assessment tools for potential evidence-based interventions. An evaluation expects to track changes in key child welfare outcomes and specific interventions for children and families. Adding to standardized assessment tools, further recommendations for practice that are specific to the population of interest are the use of evidence based home visiting programs aimed at reducing risk factors impedes services children and families (Howard & Brooks-Gunn, 2009). Overtime, the legislative update of Act 115 and results from the demonstration project for a new practice model may provide ways to increase permanency, well-being, and outcomes for children and may guide the standards used to authorize the licensing of foster care placement agencies.

There are other policy implications that should be noted due to insights gained from this study. The study's data suggested that the length (in days) of stay in the current placement setting had statistically significant impact on children with diagnosed disability as other medically diagnosed conditions. In addition, children served in foster care were discharged to different types of permanent placements and at different rates, in FFY 2012. Adoption occurred most frequently, followed by reunification with parents and primary caretaker, living with other relative, and then guardianship. However, children being adopted had the longest length of stay if foster care, followed by guardianship, reunification with parents and primary caretaker, or living with other relatives. Both the legislative update and the demonstration project results are implications for positive change to address permanency and well-being to improve outcomes for children in foster care.

There are other implications for policy change that exist, as my research findings noted that child welfare administrators needed to address the disparities regarding the length (days) of stay in foster care for children with diagnosed disabilities. Akin, Mariscal, Bass, McArthur, Bhattarai, and Bruns (2014) research identified benefits for child welfare practitioners to implement child-focused and evidence-based intervention policies to inform the care to children with serious emotional disturbance (SED). The interventions were tested in another demonstration project that found “children with SED were 3.6 times more likely to experience long-term foster care than children without an SED” (Akin, Mariscal, et al., p. 4). Policy implication insights that I gained from this study contributed to my lead in implementing a quality improvement pilot project to improve safe sleep education and reduce disparities in infant mortality at a local health department.

The results of this study suggested the need for evidence-based interventions to address the disability status; an important predictor for permanent placements among children in foster care. The study's data for children with diagnosed disability were compared to their length stay (in days) in placement setting. The findings indicated that disparate differences exist among the diagnosed types such as children as those with other diagnosed conditions had the highest mean length of stay that averaged 289 days, compared to the population sample that averaged a stay of 425 days. An overview of the literature review supports the findings in this study that children with a disability remained longer in foster care to achieve a permanent placement. The implications for policy change exist to reduce the gaps in literature and improve knowledge in research area. Welch et al.'s (2015) research determined that gaps may exist in three main areas such as (a) those related to certain children or disability types, (b) gaps arising from methodological shortcomings, and (c) perspective of individual providing care.

The study used a retrospective, nonexperimental, quantitative design to gather archived data, conduct secondary analysis, and describe data files for a cohort of Pennsylvania's 2012 foster care children. The methodological implication is supported by Belli's (2009) research not to control, manipulate or alter the variable or data files. Based on Belli's recommendations, all the analyses of results were interpreted in the format received to understand the relationships that exist, without demonstrating any cause-and-effect, or generalizing results to a larger population. As most states are working to expand their use of data and information to transform child welfare activities to effect positive social change, the theoretical implications appear to be in line with the efforts being applied by this state.

Hernandez and Hodges's (2006) theory of change encouraged child welfare professionals and stakeholders to have a shared service delivery strategy. This theory of change supports the US DHHS ACYF Children's Bureau (2012d) recommendation for an evidence based framework to integrate the goal mandated by Congress to achieve safety, permanency, and well-being of children and families. There are theoretical implications for Stokols' (1996) social ecological theory as an interdisciplinary prevention framework to improve individual's health, child welfare systems, community participation, and public policies over time. Both theories complement the theoretical framework for future practice in the child welfare system.

The benefit of learning from my research is a potential impact for policy change that will benefit the study population. A recommendation for practice is that the 1982 commonwealth of Pennsylvania's Code for Public Welfare Title 55 that sets standards to authorize the licensing of foster care placement agencies to be updated. The standards used to govern the approved agencies are written broadly and may not encourage uniformity among programs to increase permanent home placement for children with diagnosed disabilities who are discharged from foster care, and were between the ages of 0 to 6 years.

Howard and Brooks-Gunn (2009) recommended the use of evidence based home visiting program to maximize program goals when staff with credentials administers services. Casillas et al.'s (2016) research offered similar recommendations to implement evidence-based home visiting programs aimed at reducing child maltreatment. Like the population in this study, Casillas' et al. recommendations targeted caregivers of children aged of 0 and 5. The recommendation for an evidence based home visitation programs had a significant effect on program outcomes when factors such as ongoing training to staff, supervision, and monitoring the effectiveness of services were in place. Oxford, Spieker, Lohr, and Fleming's (2016) *Promoting First Relationships* report is an evidence-based home visitation programs that offers in-home interventions to families and prevent the child removal to out of home care. The recommendations to use evidence-based programs may improve planning strategies to increase permanent home placements for children with diagnosed disabilities.

Researchers are encouraged to use the congressional mandates stated in this study, as it provide states with eligibility guidelines for federal funding to achieve safety, permanency, and well-being of children and families (Child Welfare Information Gateway, 2012a; Subcommittee on Children in Substitute Care of the Pennsylvania Children's Health Coalition, 2003; US DHHS ACYF Children's Bureau, 2010a). The recommended mandates were beneficial in addressing the RQ to increase permanent home placement for children in foster care who had a diagnosed disability in this study. Brooks-Gunn (2009) and Casillas et al. (2016) recommended practice has provided new insights about some of the factors that supported or inhibited permanent placements of Pennsylvania's children who are diagnosed with disabilities and are being discharged from foster care.

Conclusion

The quantitative research design used in this study has advanced knowledge in the discipline and informed gaps in the literature for this states' code licensing foster care agencies to address strategies to increase permanent home placements among children in, or being discharged from foster care with diagnosed disabilities. The results have identified congressional mandates and recent legislative update for the commonwealth of Pennsylvania's Code for Public Welfare Title 55 that sets standards to authorize the licensing of foster care placement agencies to consider to fully integrating safety, permanency, and well-being for children and families served in the child welfare system. The evidence of these congressional mandates does suggest that the licensing code policies governing foster family care agencies in this state has national initiatives in place to reduce the number of children in foster care.

While evidence presented throughout this study indicated these mandates were implemented, a future direction in progress showed some states child welfare systems, including Pennsylvania, were transiting to adopt practices for trauma-focused care. The Children's Bureau extensive revisions of the CFSR process are to ensure conformity with congressional mandated goals and to gauge the experiences of children and families receiving state child welfare services (Child Welfare Matters, 2014). Improvements to the CFSR process are expected to guide states PIP and measure child welfare outcomes that necessity continuous quality improvement to achieve positive outcomes (Child Welfare Matters, 2014; US DHHS ACYF Children's Bureau, 2012c, 2012d). This CFSR process serves as a national policy framework for Pennsylvania's child welfare agencies to improve safety, permanency, and well-being outcomes for children and families served through the child welfare system. This process may require longitudinal follow-up studies to access whether improvements to the CFSR process offered ways to increase permanent placements at discharge and eliminate barriers that may exist for children in foster care and particularly those with diagnosed disabilities.

References

Adams-Huet, B., & Ahn, C. (2009). Bridging clinical investigators and statisticians: Writing the statistical methodology for a research proposal. *Journal of Investigative Medicine, 57*(8), 818-824. doi:10.231/JIM.0b013e3181c2996c

Adoption and Foster Care Analysis and Reporting System. (2012). *Technical bulletin #2 disability information*. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/afcars_tb2.pdf

Adoption and Foster Care Analysis and Reporting System. (2013). *AFCARS: User's guide for fiscal years 2000 to present.* Retrieved from http://www.ndacan.cornell.edu/datasets/pdfs_user_guides/AFCARS_Guide_2000-Present.pdf

Adoption and Foster Care Analysis and Reporting System. (2016a). AFCARS *foster care file code book*. Retrieved from http://www.ndacan.cornell.edu datasets/ pdfs_user_guides/AFCARSFosterCareCodebook.pdf

Adoption and Foster Care Analysis and Reporting System. (2016b). *AFCARS: User's guide for fiscal years 2000 to present.* Retrieved from http://www.ndacan. acf.hhs.gov/ datasets/pdfs_user_guides/AFCARSGuide2000toPresent.pdf

Akin, B. A., Bryson, S. A., McDonald, T. P., & Wilson, C. (2014). *Integrating safety, permanency and well-being series: A case example of the administration on children, youth and families' well-being framework, KIPP*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau and Paltech, Inc.

Akin, B. A., Mariscal, S. E., Bass, L., McArthur, V. B., Bhattarai, J., & Bruns, K. (2014). Implementation of an evidence-based intervention to reduce long-term foster care: Practitioner perceptions of key challenges and supports. *Children and Youth Services Review*, 46, 285-293. doi:10.1016/j.childyouth.2014.09.006

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.

Babbie, E. (2007). *The practice of social research* (11th ed.). Belmont, CA: Thompson Wadsworth.

Barry, A. E., Chaney, B. H., Piazza-Gardner, A. K., & Chavarria, E. A. (2014). Validity and reliability reporting practices in the field of health education and behavior: A review of seven journals. *Health Education and Behavior*, *41*(1), 12–18. doi:10.1177/1090198113483139

Belli, G. (2009). Nonexperimental quantitative research. In S. D. Lapan & M. T. Quartaroli (Eds.). *Research essentials: An introduction to designs and practices* (pp. 59–77). San Francisco, CA: Jossey-Bass Publisher.

Bethell, C. D., Kogan, M. D., Strickland, B. B., Schor, E. L., Robertson, J., & Newacheck, P. W. (2011). A national and state profile of leading health problems and health care quality for us children: Key insurance disparities and across-state variations. *Academic Pediatrics, 11*(3), S22–S33. doi:10.1016/j.acap.2010.08.011

Brault, M. W. (2012). Americans with disabilities: 2010. In *Current Population Reports* (pp.70–131). Washington, DC: U.S. Department of Commerce Economics and

Statistics, U.S. Census Bureau. Retrieved from http://www.census.gov/prod/2012pubs/p70-131.pdf

Broeck, V. J., Cunningham, S. A., Eeckels, R., & Herbst, K. (2005). Data cleaning: Detecting, diagnosing, and editing data abnormalities. *PLoS Medicine, 2*(10), 0966-0970. doi:10.1371/journal.pmed.0020267

Brown, B. L. (2010). Descriptive statistics. In N. J. Salkind (Ed.).*Encyclopedia of research design* (pp. 353-360). Thousand Oaks, CA: Sage Publications.

Burris, S., Wagenaar, A. C., Swanson, J., Ibrahim, J. K., Wood, J., & Mello, M. M. (2010). Making the case for laws that improve health: A framework for public health law research. *Milbank Quarterly, 88*(2), 169-210. doi:10.1111/j.1468-0009.2010.00595.x

Casillas, K.L., Fauchier, A., Derkash, B. T., & Garrido, E. F. (2016). Implementation of evidence-based home visiting programs aimed at reducing child maltreatment: A meta-analytic review. *Child Abuse & Neglect, 53*, 64-80. doi:10.1016/j.chiabu.2015.10.009

Cheng, H. G., & Phillips, M. R. (2014). Secondary analysis of existing data: opportunities and implementation. *Shanghai Archives of Psychiatry*, *26*(6), 371–375. doi:10.11919/j.issn.1002-0829.214171

Child Welfare Information Gateway. (2008). *The role of professional childcare providers in preventing and responding to child abuse and neglect.* Washington, DC: U.S. Department of Health & Human Services, Children's Bureau, Office on Child Abuse & Neglect.

Child Welfare Information Gateway. (2012a). *Major federal legislation concerned with child protection, child welfare, and adoption*. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Child Welfare Information Gateway. (2012b). *Reasonable efforts to preserve or reunify families and achieve permanency for children*. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Child Welfare Information Gateway. (2012d). *Supporting reunification and preventing reentry into out-of-home care*. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Child Welfare Information Gateway. (2012c). *The risk and prevention of maltreatment of children with disabilities.* Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Child Welfare Information Gateway. (2013a). *Long-term consequences of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Child Welfare Information Gateway. (2013b). *Preventing child maltreatment and promoting well-being: A network for action 2013 resource guide*. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Child Welfare Matters. (2014). *Assessing and improving continuous quality improvement systems in child welfare*. Portland, ME: National Child Welfare Resource Center for Organizational Improvement. Retrieved from: https://ncwwi.org

Collaborative Project of the Children’s Defense Fund. (2012). *Making it work: Using the guardianship assistance program (GAP) to close the permanency gap for children in foster care*. Retrieved from http://www.childwelfarepolicy.org/ tools/assets/files/GAP- report-final_11-2-12.pdf.

Commonwealth of Pennsylvania Code. (1982). *55 PA codes § 3700: Foster family care agency*. Retrieved from http://www.pacode.com/secure/data/055/chapter3700/ chap3700toc.html.

Fan, S. (2010). Covariate. In N. J. Salkind (Ed.), *Encyclopedia of research design*. (pp.285-288). Thousand Oaks, CA: Sage Publications.

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J.A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect, 36*(2), 156-165. doi:10.1016/j.chiabu.2011.10.006

Federal Interagency Forum on Child and Family Statistics. (2012). *America’s children in brief: Key national indicators of well-being, 2012.* Washington, DC: U.S. Government Printing Office.

Fitzpatrick, J. L., Sanders, J. R., & Worthen, B. R. (2010). *Program evaluation: Alternative approaches and practical guidelines* (4th ed.). Boston, MA: Pearson Education.

Frankfort-Nachmias, C., & Nachmias, D. (2008). *Research methods in the social sciences* (7th ed.). New York, NY: Worth Publishers.

Freundlich, M. (2010). *Legislative strategies to safely reduce the number of children in foster care*. Washington, DC: National Conference of State Legislatures.

Garcia-Perez, M. A. (2012). Statistical conclusion validity: Some common threats and simple remedies. *Frontiers in Psychology, 3*(325), 1-11. doi:10.3389/fpsyg.2012.00325

Goldman, J., Salus, M. K., Wolcott, D., & Kennedy, K. Y. (2003). *A coordinated response to child abuse and neglect: The foundation for practice* (3rd ed.). Washington, DC: U.S. Department of Health and Human Services, Children's Bureau, Child Abuse and Neglect User Manual Series

Gravetter, F. J., &. Forzano, L. B. (2012). *Research methods for the behavioral sciences* (4th ed.). Belmont, CA: Wadsworth Cengage Learning.

Healthy People 2020. (2010). *Maternal, infant, and child health: Disability and health.* Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health

Hernandez, M., & Hodges, S. (2006). Applying a theory of change approach to interagency planning in child mental health. *American Journal of Community Psychology, 38*(3-4), 165-173. doi:10.1007/s10464-006-9079-7

Hines, L. M. (2009). Evaluating historical research. In S. D. Lapan & M. T. Quartaroli (Eds.).*Research essentials: An introduction to designs and practices* (pp. 145-164). San Francisco, CA: Jossey-Bass Publisher.

Howard, K. S., & Brooks-Gunn, J. (2009).The role of home-visiting programs in preventing child abuse and neglect. *Future of Children, 19*(2), 119-146.

International Business Machines Corporation SPSS Statistics 23. (2016a). *IBM SPSS statistics 23, Part 1: Descriptive statistics.* Retrieved from https://www.calstatela.edu/sites/

International Business Machines Corporation SPSS Statistics 23. (2016b). *IBM SPSS statistics 23, Part 2: Test of significance.* Retrieved from https://www.calstatela.edu/sites/

International Business Machines Corporation SPSS Statistics 23. (2016c). *IBM SPSS statistics 23, Part 4: Chi-square and ANOVA.* Retrieved from https://www.calstatela.edu/sites/

Jaudes, P. K., Champagne, V., Harden, A., Masterson, J., & Bilaver, L. A. (2012). Expanded medical home model works for children in foster care. *Child Welfare, 91*(1), 9-33. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22894013

Lehman, A., O'Rourke, N., Hatcher, L., & Stepanski, E. J. (2013). *JMP for basic univariate and multivariate statistics: Methods for researchers and social scientists* (2nd ed.). Cary, NC: SAS Institute Inc.

McNabb, D. E. (2008). *Research methods in public administration and nonprofit management: Quantitative and qualitative approaches* (2nd ed.). Armonk, NY: M.E. Sharpe.

Mertens, D. M. (2014). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (4th ed.). Los Angeles, CA: Sage Publications.

Miller, V. A., Reynolds, W. W., Ittenbach, R.F., Luce, M. F., Beauchamp, T. L., & Nelson, R. M. (2009). Challenges in measuring a new construct: Perception of voluntariness for research and treatment decision making. *Journal of Empirical Research on Human Research Ethics, 4*(3), 21-31. doi:10.1525/jer.2009.4.3.21

Muijs, D. (2011). *Doing quantitative research in education: With SPSS* (2nded.).Thousand Oaks, CA: Sage Publications.

National Council of Juvenile and Family Court Judges. (2013). *Disproportionality rates for children of color in foster care: Technical assistance bulletin.* Reno, NV: University of Nevada.

National Data Archive on Child Abuse and Neglect Child File Data License. (2013). *Data licenses: National child abuse and neglect data system [NCANDS] child file*. Retrieved from http://www.ndacan.cornell.edu/datasets/order_forms/NCANDS_Child_File_Data_License_2013-7-13.pdf

National Governors Association Center for Best Practices. (2010). *State efforts to safely reduce the number of children in foster care*. Retrieved from http://www.nga.org/

National Institutes of Health, Office of Extramural Research. (2008). *Protecting human research participants*. Retrieved from http://phrp.nihtraining.com/users/PHRP.pdf

National Technical Assistance and Evaluation Center for Systems of Care. (2008). *An individualized, strengths-based approach in public child welfare driven systems of care*. Retrieved from https://www.childwelfare.gov/

National Statistical Service. (n.d.). *Sample size calculator*. Retrieved from http://www.nss.gov.au/nss/home.nsf/pages/Sample+size+calculator.

Oxford, M. L., Spieker S. J., Lohr M. J., & Fleming C. B. (2016). Promoting first relationships: Randomized trial of a 10-week home visiting program with families referred to child protective services. *Child Maltreatment, 21*(4) 267-277. doi:10.1177/1077559516668274

Paxson, C., & Haskins, R. (2009). Preventing child maltreatment: Introducing the issue. *Future of Children, 19*(2), 3-18. Retrieved from http://www.futureofchildren.org/sites/futureofchildren/files/media/preventing_child_maltreatment_19_02_fulljournal.pdf

Pennsylvania Department of Human Services. (2016). *Annual Child Protective Services Report, 2016*. Retrieved from http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_260865.pdf

Pennsylvania Department of Public Welfare, Office of Children, Youth, and Families. (2009). *Pennsylvania's guardianship assistance program: Bulletin 3130-03-01/3140-03-07*. Retrieved from http://www.fosteringconnections.org/tools/assets/ files/ PAPermanent-Legal-Custodian-Policy.pdf

Powers, L. E., Geenen, S., Powers, J., Pommier-Satya, S., Turner, A., Dalton, L. D., … , Swank, P. (2012). My life: Effects of a longitudinal, randomized study of self-determination enhancement on the transition outcomes of youth in foster care and special education. *Children and Youth Services Review, 34*(11), 2179–2187. doi:10.1016/j.childyouth.2012.07.018

Quartaroli, M. T. (2009). Quantitative data analysis. In S. D. Lapan & M. T. Quartaroli (Eds.).*Research essentials: An introduction to designs and practices* (pp. 103-130). San Francisco, CA: Jossey-Bass Publisher.

Roosevelt, E. (1960). *You learn by living: Eleven keys for a more fulfilling life*. New York, NY: Harper Collins Publishers.

Rotabi, K. S. (2007). Ecological theory origin from natural to social science or vice versa? A brief conceptual history for social work. *Advances in Social Work, 8*(1), 113-129. Retrieved from https://journals.iupui.edu/index.php/advancesinsocialwork/article/view/135

Rudestam, K. E., & Newton, R. R. (2007). *Surviving your dissertation: A comprehensive guide to content and process* (3rd. ed.). Thousand Oaks, CA: Sage Publications.

Samuelson, A. (2010). *Best practices for parent education and support programs: What works, Wisconsin—research to practice series, Issue 10*. Retrieved from http://whatworks.uwex.edu/attachment/ whatworks_10.pdf

Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Li, S. (2010). *Fourth national incidence study of child abuse and neglect (NIS–4): Report to Congress.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Sege, R. D., & De Vos, E. (2010). Evidence-based health care for children: What are we missing? *Commonwealth Fund, 1395*(85), 1-14.

Simms, M. D., Dubowitz, H., & Szilagyi, M. A. (2000). Health care needs of children in the foster care system. *Pediatrics*, *106*(Supplement 3), 909-918. Retrieved from http://pediatrics.aappublications.org/content/106/Supplement_3/909.short

Smith, A. K., Ayanian, J. Z., Covinsky, K. E., Landon, B. E., McCarthy, E. P., Wee, C. C., & Steinman, M, A. (2011). Conducting high-value secondary dataset analysis: An introductory guide and resources. *Journal of General Intern Medicine, 26*(8), 920-929. doi:10.1007/s11606-010-1621-5

Sommers, B. D., & Rosenbaum, S. (2011). Issues in health reform: How changes in eligibility may move millions back and forth between Medicaid and insurance exchanges. *Health Affairs*, *30*(2), 228-236. doi:10.1377/hlthaff.2010.1000

Stalker, K., & McArthur, K. (2012). Child abuse, child protection and disabled children: A review of recent research. *Child Abuse Review, 21*(1), 24–40. doi:10.1002/car.1154

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion, 10*(4), 282-298. doi:10.4278/0890-1171-10.4.282

Strickland, B. B., van Dyck, P. C., Kogan, M. D., Lauver, C., Blumberg, S. J., Bethell, C. D., & Newacheck, P.W. (2011). Assessing and ensuring a comprehensive system of services for children with special health care needs: A public health approach. *American Journal of Public Health*, *101*(2), 224-231. doi:10.2105/AJPH.2009.177915

Subcommittee on Children in Substitute Care of the Pennsylvania Children’s Health Coalition. (2003). *Promoting healthy outcomes for children in substitute care: A guide for judges, court personnel and child welfare professionals in Philadelphia*. Retrieved from http://dhs.phila.gov/intranet/scintrahomepub.nsf/AttachmentsByTitle/Promoting+Healthy+Outcomes+for+Children+in+Substitute+Care/$FILE/PromotingHealthyOutcomes.pdf

Suresh, K.P., & Chandrashekara, S. (2012). Sample size estimation and power analysis for clinical research studies. *Journal of Human Reproductive Science*, *5*(1), 7-13. doi:10.4103/0974-1208.97779

Task Force on Health Care for Children in Foster Care. (2005). *Fostering health: Health care for children and adolescents in foster care* (2nd ed.). New York, NY: American Academy of Pediatrics District II.

Taplin, D. H., Clark, H., Collins, E., & Colby, D. C. (2013). *Theory of change technical papers: A series of papers to support development of theories of change based on practice in the field*. New York, NY: ActKnowledge.

U.S. Department of Health & Human Services. (2005). *A report to Congress on adoption and other permanency outcomes for children in foster care: Focus on older children*. Washington, DC: Children’s Bureau. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/congress_adopt.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children's Bureau. (2000). *Child welfare outcomes 1998: Annual* *report.* Retrieved from http://archive.acf.hhs.gov/programs/cb/pubs/cwo98/cwo98.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children's Bureau. (2006). *Child neglect: A guide for prevention, assessment and intervention* (3rded.). Retrieved from http://www.childwelfare.gov/pubs/usermanuals/neglect /neglect.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children’s Bureau, Region III. (2009). *Commonwealth of PA department of public welfare office of children, youth and families: 5-year child and family services plan (CFSP) federal fiscal years 2010 – 2014.* Retrieved from http://www.dpw.state.pa.us/cs/groups/webcontent/documents/report/s_002149.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children’s Bureau. (2010a). *The children’s bureau: A legacy of services … a vision for change*. Retrieved from http://www.acf.hhs.gov/programs/cb/aboutcb/cb_brochure.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children’s Bureau. (2010b). *Child Welfare Outcomes 2004–2007: Report to Congress.* Retrieved from http://www.acf.hhs.gov/programs/cb/ pubs/cwo04-07/cwo04-07.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children’s Bureau. (2011). *Tip sheet for early childhood-child welfare partnership: Policies and programs that promote educational access, stability,* *and success for vulnerable children and families*. Retrieved from http://www.childwelfare.gov/pubs/ec-cw-tipsheet.pdf

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children's Bureau. (2012a). *Adoption and foster care analysis and reporting system (AFCARS): Guide to an AFCARS assessment review* (5th.ed.). Washington, DC: Government Printing Office. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/afcars_assessment_review_guide.pdf

U.S. Department of Health & Human Services, Administration on Children Youth & Families, Children's Bureau. (2012b). *Establishing and maintaining continuous quality improvement (CQI) systems in state child welfare agencies*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/im1207.pdf

U.S. Department of Health & Human Services, Administration on Children Youth & Families. (2012c). *Integrating safety, permanency, and well-being for children and families in child welfare*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/acyf_fy2012_projects_summary.pdf

U.S. Department of Health & Human Services, Administration on Children Youth & Families. (2012d). *Promoting social and emotional well-being for children and youth receiving child welfare services*. Washington, DC: Government Printing Office. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/im1204

U.S. Department of Health & Human Services, Administration for Children, Youth & Families, Children's Bureau. (2012e). *A report to congress on interjurisdictional* *adoption of children in foster care*. Retrieved from https: //www.acf.hhs.gov/sites/default/files/cb/ij_adopt.pdf

U.S. Department of Health & Human Services, Administration for Children and Families, Administration for Children, Youth & Families, Children's Bureau. (2013). *Child maltreatment 2012.* Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf

U.S. Department of Health & Human Services, Administration for Children and Families, Administration for Children, Youth & Families, Children's Bureau. (2014). *Child welfare outcomes 2009-20012: Report to Congress.* Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cwo09_12.pdf

U.S. Department of Health & Human Services, Health Resources and Services Administration Maternal and Child Health Bureau. (2010). *Rethinking MCH: The life course model as an organizing framework*. Retrieved from http://www.hrsa.gov

U.S. Department of Health & Human Services, Office of the Surgeon General. (2009). *The surgeon general's call to action to promote healthy homes*. Washington, DC: US Department of Health &Human Services.

Vandivere, S. & Malm, K. (2015). *Family finding evaluations: A summary of recent findings*. Washington, DC: Child Trends Publication.

Welch, V., Jones, C., Stalker, K., & Stewart, A. (2015). Permanence for disabled children and young people through foster care and adoption: A selective review of international literature. *Children and Youth Services Review*, *53*, 137-146. doi.10.1016/j.childyouth.2015.03.017

Zimmerman, F., & Mercy, J.A. (2010*). Better start: Child maltreatment prevention as a public health priority*. Retrieved from http://www.zerotothree.org

Appendix A: U.S. Population of Children Served in FFY 2012

Table F1

U.S. Population of Children Served in FFY 2012

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Alabama	7907	1.2	1.2	1.2
	Alaska	2727	.4	.4	1.7
	Arizona	21267	3.3	3.3	5.0
	Arkansas	7513	1.2	1.2	6.2
	California	84820	13.3	13.3	19.5
	Colorado	11184	1.8	1.8	21.2
	Connecticut	6068	1.0	1.0	22.2
	Delaware	1286	.2	.2	22.4
	District of Columbia	2276	.4	.4	22.7
	Florida	34868	5.5	5.5	28.2
	Georgia	13625	2.1	2.1	30.3
	Hawaii	2178	.3	.3	30.7
	Idaho	2410	.4	.4	31.0
	Illinois	22588	3.5	3.5	34.6
	Indiana	18292	2.9	2.9	37.5
	Iowa	10441	1.6	1.6	39.1
	Kansas	9473	1.5	1.5	40.6
	Kentucky	11864	1.9	1.9	42.4
	Louisiana	7514	1.2	1.2	43.6
	Maine	2179	.3	.3	44.0
	Maryland	7931	1.2	1.2	45.2
	Massachusetts	13640	2.1	2.1	47.3
	Michigan	22391	3.5	3.5	50.8
	Minnesota	10729	1.7	1.7	52.5
	Mississippi	5999	.9	.9	53.5
	Missouri	15461	2.4	2.4	55.9
	Montana	3068	.5	.5	56.4
	Nebraska	8055	1.3	1.3	57.6
	Nevada	7705	1.2	1.2	58.8
	New Hampshire	1166	.2	.2	59.0
	New Jersey	11615	1.8	1.8	60.8
	New Mexico	3558	.6	.6	61.4
	New York	34541	5.4	5.4	66.8
	North Carolina	13163	2.1	2.1	68.9
	North Dakota	1887	.3	.3	69.2
	Ohio	21233	3.3	3.3	72.5
	Oklahoma	13636	2.1	2.1	74.6
	Oregon	12515	2.0	2.0	76.6
	Pennsylvania	23523	3.7	3.7	80.3
	Rhode Island	2935	.5	.5	80.7

(table continues)

		Frequency	Percent	Valid Percent	Cumulative Percent
	South Carolina	6522	1.0	1.0	81.8
	South Dakota	2543	.4	.4	82.2
	Tennessee	13960	2.2	2.2	84.3
	Texas	46505	7.3	7.3	91.6
	Utah	4897	.8	.8	92.4
	Vermont	1571	.2	.2	92.6
	Virginia	7507	1.2	1.2	93.8
	Washington	14685	2.3	2.3	96.1
	West Virginia	7394	1.2	1.2	97.3
	Wisconsin	10787	1.7	1.7	99.0
	Wyoming	1779	.3	.3	99.3
	Puerto Rico	4772	.7	.7	100.0
	Total	638153	100.0	100.0	

Table F2

PA Children Served

		Frequency	Percent
Total	Pennsylvania	23523	100.0

Table F3

Foster Home Placements

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Pre-adoptive home	727	3.1	3.1	3.1
	Foster home, relative*	5559	23.6	23.6	26.7
	Foster home, non-relative*	9980	42.4	42.4	69.2
	Group home	3076	13.1	13.1	82.2
	Institution	2562	10.9	10.9	93.1
	Supervised independent living	439	1.9	1.9	95.0
	Runaway	339	1.4	1.4	96.4
	Trial home visit	839	3.6	3.6	100.0
	Total	23521	100.0	100.0	
Missing	System	2	.0		
Total		23523	100.0		

**n* = 15,539 foster care home placements

Table F4

Children Aged 0 to 6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1141	13.2	13.2	13.2
	1	1629	18.9	18.9	32.1
	2	1492	17.3	17.3	49.5
	3	1262	14.6	14.6	64.1
	4	1169	13.6	13.6	77.7
	5	1046	12.1	12.1	89.8
	6	878	10.2	10.2	100.0
	Total	8617	100.0	100.0	

Table F5

Permanent Home Placements

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Reunified with parent, primary caretaker	1535	48.5	48.5	48.5
	Living with other relative(s)	189	6.0	6.0	54.4
	Adoption	1284	40.5	40.5	94.9
	Guardianship	160	5.1	5.1	100.0
	Total	3168	100.0	100.0	

Table F6

Diagnosed Disabilities

		Mental Retardation	Visually or Hearing Impaired	Physically Disabled	Emotionally Disturbed	Other Diagnosed Condition
N	Valid	344	344	344	344	344
	Missing	0	0	0	0	0
M		.04	.03	.21	.12	.68
SD		.198	.168	.409	.324	.466
Variance		.039	.028	.168	.105	.217
Sum		14	10	73	41	235