Ohio CASA Evaluation

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About us

The Ohio Colleges of Medicine Government Resource Center's mission is to identify, research, and spread innovative practices to improve access to quality health care for all Ohioans through partnerships with health care, state, and academic leaders.

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Executive Summary

Introduction

Although the Court Appointed Special Advocate (CASA) model was created more than 45 years ago and is deployed in 49 states, data about the program's effectiveness are incomplete. Previous studies have identified promising outcomes, but many of the assessments are small and dated. Moreover, previous studies have not fully controlled for a range of factors that could confound results. And no previous studies have evaluated the impact of the appointment of a CASA volunteer on the outcomes of the children who appear in Ohio's juvenile court as a result of abuse, neglect, or dependency. With children's lives and well-being in the balance, the need for accurate data is clear.

The Ohio CASA/GAL (guardian ad litem) Association (Ohio CASA) entered into a collaborative partnership with the Ohio Department of Job and Family Services (ODJFS), and the Ohio Department of Medicaid (ODM) to evaluate the impact of the appointment of a CASA volunteer on selected outcomes. Those organizations commissioned an independent evaluation by the Ohio Colleges of Medicine Government Resource Center (GRC) to assess the impact of the appointment of a CASA volunteer on family stability, child health, and wellness outcomes. The evaluation sought to answer the following questions:

1. What is the impact of the appointment of a CASA volunteer on children's experiences in the child welfare system?

2. What is the impact of the appointment of a CASA volunteer on children's health care?

3. Does the impact of the appointment of CASA volunteer differ by a child's race?

4. What are the characteristics of Ohio children and their families who have had a CASA volunteer appointed to represent the best interests of the child?

As a complement to this quantitative study, the GRC also gathered information from individuals with lived experience in foster care (results in Part 2 of this report). These individuals have first-hand knowledge of the child welfare system and can provide valuable insights regarding support and care that is provided to youth in the child welfare system. Their perspectives can also help policymakers and other stakeholders to better understand the needs of children in foster care.

Methods

The data included in this study came from three administrative sources: (1) Ohio Medicaid administrative data; (2) Ohio's Statewide Automated Child Welfare Information System

(SACWIS); and (3) CASA program data from case management systems within each participating county. Individual information across the three administrative sources was linked to provide a comprehensive individual-level dataset for this study.

Treatment and comparison groups were defined as follows: *CASA treatment groups* were drawn from six county CASA programs representing a mix of demographic characteristics. Children were considered treated if they were assigned a CASA volunteer no later than 90 days after they were removed from their home and placed in a custodial arrangement. Because some children experienced repeated removals, the analysis was limited to the first episode of removal from the home during the study period (first eligible legal custody episode between 2015 and 2016). Additionally, the treatment group was restricted to children who were assigned a CASA volunteer, as opposed to a CASA staff member serving as the appointed guardian ad litem. The study included two comparison groups. *Within-county comparison groups* included children in counties with a CASA program who were not assigned a CASA volunteer due to capacity or other administrative reasons. An *across-county comparison group* included children from comparable counties that were matched on size where there were no CASA programs. The quantitative results were adjusted for covariates to control for potential confounding factors. Variables used for control included the following: child's behavioral health diagnoses; geographic Isolation Index; Ohio Children's Opportunity Index (OI); parent behavioral health diagnoses; prior intakes; prior out of home placement(s) (OOHP); race/ethnicity; and gender.

The two focus groups were conducted with young adults who were recruited from the Columbus State Scholar Network (CSSN), a program to provide students who have a history in foster care with peer support and academic mentoring to succeed in college. A total of 21 students participated in the focus groups, which were conducted in- person at Columbus State Community College in March 2023. Focus groups questions were developed in collaboration with the Ohio Youth Advisory Board, a statewide organization for young people who have experienced foster care.

Quantitative Results

Across all comparison groups, children who were appointed CASA volunteers were more likely to have a mother or father diagnosed with a behavioral health condition. In addition, the impact of CASA differed for the within-county and across-county comparisons. Generally, the findings suggested that the appointment of a CASA volunteer was associated with positive placement-related outcomes.

Results of the within-county comparison suggested that young people who were appointed a CASA volunteer:

- Spent less time in an OOHP;
- Were less likely to re-enter OOHP following discharge;
- Were more likely to enter a permanent placement; and
- Were more likely to be reunified with family.

The across-county comparison identified fewer significant effects associated with assignment of a CASA volunteer. However, the findings suggested that the impact of CASA volunteer assignment varies by geography and race.

- In both metropolitan and rural counties, young people with a behavioral health diagnosis who were appointed a CASA volunteer spent a smaller proportion of their placement time in a restrictive placement setting compared to young people with behavioral health issues who were from counties without a CASA program.
- In metropolitan counties, appointment of a CASA volunteer was associated with a higher rate of placement changes; while no effect of CASA volunteer assignment on placement changes was identified in rural counties.
- In metropolitan counties, appointment of a CASA volunteer was associated with a higher number of well-child visits and a lower number of preventable emergency department visits. In contrast, in rural areas, the appointment of a CASA volunteer was associated with a higher number of preventable emergency department visits.
- In rural counties, appointment of a CASA volunteer was associated with a reduction in OOHP for White children, while in metropolitan areas, appointment of a CASA volunteer was associated with an increase in OOHP for children of color.
- In metropolitan counties, appointment of a CASA volunteer was associated with a lower likelihood of reunification for White children and no association with reunification for children of color.

While the analysis accounted for many treatment and comparison group differences related to demographic and clinical characteristics, some sources of potential bias were not possible to control. For example, the across-county comparison may be affected by unmeasured differences among counties, such as variation across local court systems and availability of other services, which are likely to have an impact on outcomes. The within-county analysis may be affected by unmeasured factors related to selection and participation of children assigned a CASA volunteer. The results of both analysis strategies must be considered in light of these limitations.

Focus Group Results

The facilitated discussions with young adults provided a personal, nuanced view of youth experiences of foster care. Many of the challenges they described could be reduced with more effective support from adults assigned to advocate for them. Several experiences were

common among participants, and most of them could be ameliorated with the additional time, trust, and active engagement of an adult.

Focus group participants described needing greater personal safety and more protection from abuse; they cited the need for adults to believe and act on their reports of abuse, stress, and trauma. Participants reported the lack of help gaining basic necessities, such as clothing, educational services, transportation, and financial resources. Many discussed experiences of bias based on race, gender, and culture as well as alienation within foster homes.

Focus group participants reported wishing they had been given a much stronger voice in several matters that directly impacted their lives, from court proceedings and decisions about their placements to the treatment of health conditions, including mental health. Some felt exploited for income from the foster care system, and some expressed the need for greater skill-building as they approached transition from foster care. Participants cited the importance of including the perspectives of people who have experience in foster care when designing programs and training professionals to help youth in foster care.

These and other key findings from the focus groups led to the following best practice recommendations and implications for CASA/GAL training:

- Incorporate youths' perspectives in decision-making about their placement;
- Support shared decision-making for healthcare;
- Approach youths' race, culture, and identity from a perspective of cultural humility;
- Invest in efforts to build relationships with youth;
- Provide trauma-informed care from within the CASA/GAL volunteer role; and
- Ensure youth have clarity and transparency about their financial rights and the resources that are available to them.

Conclusion

In all, this study took steps beyond those of previous studies by controlling for a range of factors that could otherwise confound the results. The design was facilitated through access to important information about children and families that can be found in medical claims records (e.g., geographic location of residence and behavioral health diagnoses) and child welfare databases (e.g., histories of child welfare involvement). Because of this, the estimates of the association between the appointment of a CASA volunteer and child outcomes may be closer to causal estimates than in previous studies. However, these estimates may be improved with additional information about characteristics of children and families that are likely to affect outcomes (e.g., parental education and involvement in the criminal justice system and county resources, such as funding and access to treatment).

Part 1: Quantitative Report

Introduction

Children removed from their homes as a result of abuse, neglect, or dependency contend with a range of challenges, all of which can have long-term impacts on their well-being. Emotional trauma; disruption of school settings and social connections; separation from siblings and other family members; stigma and discrimination—these challenges and others can be compounded by children's uncertainty about their future and a lack of personal agency to control what happens. Children in foster care may face inadequate resources to address their mental health and educational needs.

The CASA model was created in 1977 to ensure that children who have experienced abuse or neglect have a safe, permanent home and the opportunity to thrive. CASA volunteers help ensure children's best interests are considered and addressed by the court and others involved in their care. The CASA model includes four core functions led by a trained volunteer advocate who is appointed by the court:

1. Investigation: CASA volunteers are responsible for conducting interviews with significant people (e.g., relatives, teachers) and reviewing relevant court documents to understand and inform the court of the details of each child's case, including their home environment, relationships, and needs.

2. Facilitation: CASA volunteers work to address each child's unique needs by identifying appropriate resources and services and facilitating collaboration between all parties involved in a case.

3. Advocacy: CASA volunteers make recommendations to the court for the child's best interests related to custody, placement, and services.

4. Monitoring: CASA volunteers assure that orders of the court and plans of child protective services agencies are carried out as directed.

Since this model was established, CASA programs have expanded to 49 states and the District of Columbia and serve over 200,000 children per year. In 2022 Ohio reported 46 CASA programs with 2,273 volunteers serving 7,718 children in 57 counties.

Studies have identified positive outcomes associated with the CASA model. There is evidence that children with a CASA volunteer are more likely to receive needed services and experience more timely progress through the child welfare and family court system (Caliber Associates, 2004). They are less likely to be moved from placement to placement (Calkins & Millar, 1999),

more likely to be placed in permanent custody (Poertner & Press, 1990), and less likely to re-enter foster care (Powell & Speshock, 1996). The appointment of a CASA volunteer is associated with better academic performance and fewer conduct problems in school (Waxman et al., 2009). Among children of color, one study reported that the appointment of a CASA volunteer may reduce racial differences in permanent placement; children of color who are appointed a CASAs volunteer were more likely to have a plan for permanency (Abramson, 1991).

While the results of these studies are promising, most studies of the CASA model are small and outdated. None have evaluated the impact of the appointment of a CASA volunteer on the outcomes of the children who appear in Ohio's juvenile courts as a result of abuse, neglect or dependency. Children who are appointed a CASA volunteer may have characteristics and risk factors that differ from those of children who are not appointed a CASA volunteer. A rigorous evaluation can account for these differences and provide a more accurate estimate of the true impact of representation by a CASA volunteer. A rigorous evaluation that demonstrates the positive impact of CASA programs in Ohio could garner national attention and significant aid to support Ohio's CASA programs. It could also identify program elements that could be improved through training and process improvement. All of this could bring more evidence-based help to children—in Ohio and across the country.

Ohio CASA entered into a collaborative partnership with the ODJFS, and the ODM to assess the impact on outcomes when a CASA volunteer is appointed to represent children who appear in Ohio's juvenile courts as a result of abuse, neglect, or dependency. Those organizations commissioned an independent evaluation by the GRC to study the impact of Ohio's CASA volunteers on family stability, child health, and wellness outcomes. This evaluation seeks to answer the following questions:

1. What is the impact of the appointment of a CASA volunteer on children's experiences in the child welfare system?

2. What is the impact of the appointment of a CASA volunteer on children's health care?

3. Does the impact of the appointment of a CASA volunteer differ by a child's race?

4. What are the characteristics of children who are appointed a CASA volunteer and the families of these children?

Methodology

GRC implemented a quasi-experimental design to assess the impact of appointment of a CASA volunteer on children's outcomes. The study protocol was reviewed and approved by the Ohio State University Institutional Review Board in December 2021.

Data Sources

The quantitative data for the study come from three administrative sources: (1) Ohio Medicaid claims; (2) Ohio's Statewide Automated Child Welfare Information System (SACWIS); and (3) CASA program data from the CASA Manager systems.

Medicaid Administrative Data

All children and youth in out-of-home placement are eligible for Medicaid health care coverage through Title IV-E of the Social Security Act. Medicaid data includes demographic characteristics, enrollment history, and health services utilization for all Medicaid enrollees in Ohio. The data include robust information related to all services for which Medicaid was the primary payer, including diagnostic information, type and dates of all services rendered, and medications prescribed.

Statewide Automated Child Welfare Information System (SACWIS)

SACWIS is a case management system maintained by the ODJFS and Ohio's 88 county public services agencies. SACWIS is the case record for all Ohio children who have had child welfare system involvement. For the current evaluation, GRC gathered records regarding cases of child maltreatment, legal custody, and OOHP from 2015 through 2019.

CASA Program Data

CASA program data were obtained from CASA Manager. CASA Manager is a case management information system used by local CASA programs to document information about referrals, legal custody, placements, case closures, and demographics. It also includes information about volunteers, such as their demographic characteristics and educational background, caseload size, hours and contacts made with the child, family, and other individuals or organizations involved in the case.

Data Linkage

GRC's study linked individual records across the three administrative sources to provide a comprehensive individual-level dataset. The data linkage process included three phases:

1. Cleaning and formatting for consistency across the three data sources' unique identifiers available in each dataset.
2. Applying a deterministic linkage process to link Medicaid and SACWIS records that matched exactly based on Social Security Number (SSN) and date of birth (DOB) and to link CASA and Medicaid records that matched exactly based on first name, last name, and DOB.
3. Applying a probabilistic linkage process to link records that did not include reliable individually unique identifiers, or did not match deterministically due to differences in spelling, nicknames, inversion of dates in a DOB field, etc. The probabilistic linkage process was carried out using Linkplus software, which calculates a similarity score based on a combination of common identifiers, such as first name, last name, date of birth, gender, county, and address(es). Manual review of potential matches was then conducted to assign a confidence threshold for identifying a match. This process was used to link Medicaid to SACWIS records that have a missing or invalid SSN. It was also used to link Medicaid and SACWIS records with CASA program data, since CASA program data do not include SSN. For more information, see **Appendix A. Record Linkage Procedure.**

The CASA program datasets included records for 8,229 children from participating CASA programs between 2006 and 2019. Of those children, 7,719 (94%) had matching Medicaid Enrollment records, and 6,338 (77%) had matching SACWIS intake records indicating involvement with the child welfare system.

Sample

Our study sample contained children who experienced an OOHP with a start date between January 1, 2016, and December 31, 2017. By limiting the selection window to two years, data prior to 2016 were used to adjust for prior child welfare experiences and data after 2017 were used to evaluate outcomes. We restricted the sample to legal custody episodes of at least 90 days to minimize the number of cases in our analyses that did not require substantial advocacy from either a CASA volunteer or attorney GAL. Children were also excluded if their placement ended due to events that were unlikely to be modified by CASA involvement, such as reaching adulthood and aging out of child protective services, death, or leaving foster care without permission. The sample was further restricted to cases under the jurisdiction of Ohio's juvenile courts, additionally excluding cases with delinquency as a removal reason.

Table 1. Participating CASA Programs

			Case Types Served by CASA Volunteers				Children Served by Program			
County	Urban / Rural	People of Color	Neglect	Dependency	Abuse	Program Start Year	2016	2017	% Eligible	Additional Info
Butler	Mix of Urban/ Rural	14%	Y	Y	Y	1988	215	274	25-30%	Does not take children placed out of county, does not take safety risks (if CW won't go without the police), children have both an attorney GAL and a CASA volunteer.
Clinton	Rural	5%	Y	Y	Y	2017	13	57	40%	Program began in 2017.
Franklin	Urban	31%	Y	Y	Y	1991	728	99	27-33%	Staff attorneys will review the cases and be appointed to the more severe cases: abuse, multiple children, and/or multiple concerns.
Lucas	Urban	27%	Y	Y	Y	1980	888	846	87%	CASA volunteers choose cases they would like to take. After three circulations among volunteers, cases are assigned to attorney GALs.
Seneca	Mix of Urban/ Rural	6%	Y	Y	N	1990	~70	~70	100%	Very few cases are staff-served, 1-2 cases per volunteer.
Summit	Mix of Urban/ Rural	20%	Y	Y	N	1981	1123	1069	~ 100%	Staff social workers are appointed to the most difficult cases

Treatment and Comparison Groups

CASA treatment groups were drawn from six county CASA programs representing a mix of demographic characteristics (see **Table 1**). Children were considered treated if they were assigned a CASA volunteer no later than 90 days after the start of their first eligible legal custody episode. Additionally, we restricted the treatment group to children who were appointed a CASA volunteer, as opposed to a CASA staff member serving as guardian ad litem.

Courts and CASA programs consider a variety of factors in selecting which children will be assigned a CASA volunteer. For example, some courts assign CASA volunteers to children who are most likely to benefit from them. Some courts avoid assigning CASA volunteers to children with complex family challenges that could be difficult for a volunteer to manage. These selection factors are unique to each county, difficult to measure, and are likely to influence the outcome measures of interest in this study. Thus, comparing outcomes of children with and without a CASA volunteer may produce biased estimates of the impact of CASA volunteer assignment.

To reduce selection bias, we considered a range of attributes, such as prior child welfare involvement, demographics, and behavioral health to identify comparison groups that were similar to the treatment group (see Measures for additional detail). We implemented two comparison methods. In one method (within-county analysis), we limited the analysis to two counties where the assignment of a CASA volunteer was primarily based on volunteer availability, rather than specific selection criteria. Children who were appointed a CASA volunteer were compared to children with similar attributes in the same counties who were not appointed a CASA volunteer. In the other comparison method (across-county comparison), the treatment group from all six counties was compared to similar children in counties without CASA programs. For this analysis, comparison counties were chosen based on their population size according to census data.

Measures

The quantitative component of the evaluation was conducted using administrative data to estimate attributes and outcomes associated with the appointment of a CASA volunteer. This section introduces the outcome measures that were examined and describes measurable covariates that were used to improve the accuracy of estimates. Many children had more than one OOHP during the study period. Prior OOHPs may affect decisions regarding assignment to a CASA program and the likelihood and duration of future OOHPs; therefore, measures created in this study focus on events related to the first OOHP episode during the study timeframe, unless otherwise specified.

Dependent Measures (Outcomes)

The dependent measures focus on outcomes that may be associated with the appointment of a CASA volunteer. **Table 2** below describes the outcome measures that are derived from Medicaid and SACWIS data. For the dependent measure of time in a restrictive placement setting, behavioral health diagnosis was identified as a driving factor. Thus, the analysis was limited to children with a behavioral health diagnosis in order to isolate the impact of CASA volunteer assignment from the impact of behavioral health.

Table 2. Outcome Measures

Measure Short Name	Description	Primary Source
Placement changes	Number of placement changes while in first eligible legal custody episode	SACWIS
Time in out-of-home placement (OOHP)[a]	Likelihood of OOHP during a given week from the start of first eligible legal custody episode until the end of the study period	SACWIS
Re-entry into OOHP	Likelihood of reentry within one year of discharge	SACWIS
Reunification with family	Odds of reunification with parents, legal guardian, or custodian upon discharge from first eligible legal custody episode	SACWIS
Permanency placement	Odds of reunification with parent, permanent placement with relative, or adoption upon discharge from first eligible legal custody episode	SACWIS
Time in a restrictive placement[b,c]	Likelihood of a restrictive OOHP during a given week from the start of the first legal custody episode until the end of the study period	SACWIS
Timely well-child visits	Number of preventative care visits with a primary care provider per year during the first eligible legal custody episode	Medicaid
Preventable emergency room Visits[d]	Number of preventable emergency room visits per year during the first eligible legal custody episode	Medicaid

[a]A week was considered an "OOHP week" if a child was in an OOHP for three or more days.
[b]We defined a restrictive week to be one where a child was in a restrictive placement for three or more days.
[c]Only considered for children with a behavioral health diagnosis.
[d]Using the NYU ED Algorithm (Billings et al., 2012), we classified visits as preventable if patient information indicated that immediate medical care was not required within 12 hours or could have been safely provided in a primary care setting.

Independent Measures (Covariates)

Covariates were included in the analysis to adjust for the potential impact of child welfare experience prior to the study period and other attributes (e.g., behavioral health) that may be

correlated with outcome measures. **Table 3** below describes covariates that we controlled for in quantitative analyses in order to limit potential confounding factors (i.e., to control for features that might be associated with both the outcomes of interest and the appointment of a CASA volunteer).

Table 3. Independent Measures

Measure	Description	Primary Source
Child Behavioral Health Diagnosis	Any behavioral health or intellectual or developmental disability diagnoses	Medicaid in past year
Geographic Isolation Index	A measure of the rurality of the child's census tract	Linked by parent address obtained from SACWIS
Ohio Children's Opportunity Index (OI)	Overall measure capturing the area's deprivation for the family household of a child at the tract level	Linked by parent address obtained from SACWIS
Parent Behavioral Health Diagnosis	Any mental health or substance use disorder (SUD) diagnosis	Medicaid
Prior Intakes	Number of prior intakes in the previous three years	SACWIS
Prior OOHPs	Number of prior OOHPs in previous three years	SACWIS
Race / Ethnicity	Race / Ethnicity	Medicaid
Sex	Child's sex	SACWIS
Tract Percentage POC	The percentage of people of color in the child's census tract	Linked by parent address obtained from SACWIS

Analysis

To conduct the within-county analysis, we compared eligible children in Ohio county CASA programs who were appointed a CASA volunteer to eligible children in the same counties who were not appointed a CASA volunteer. To conduct the across-county analysis, we compared participants in Ohio county CASA programs to children in similar Ohio counties without CASA programs. Due to the diverse composition and large sample size of the across-county analysis, we were able to consider the impact of geographic region on the effect of CASA assignment by conducting separate analyses for rural and metropolitan counties. We were also able to examine the interaction between race and CASA assignment within both the rural and metropolitan analyses.

In each analysis, we regressed outcomes of interest on an indicator of the appointment of a CASA volunteer. Because the treatment and comparison groups may be compositionally different in ways that confound the effect of the appointment of a CASA volunteer with other factors (e.g., history of prior OOHP), regression models also included covariates for the

independent measures outlined in **Table 2** to control for the impact of potential confounding factors.

The nature of the outcome determined the choice of regression model. We used logistic regression to model reunification with family and permanency placement. For outcomes which counted the number of placement changes, timely well-child visits, or preventable emergency room visits, we used Poisson regression with an offset to adjust for the length of the legal custody episode, thus controlling for the amount of time the individual was observed, to model counts. We fit a Cox Proportional-Hazards model for time until re-entry to an OOHP. These models account for right censoring, when the observation period ends and the outcome event has not yet happened. For the longitudinal analyses for OOHP and restrictive placement, we used logistic generalized estimating equations with Autoregressive AR-1 correlation structures. We chose this correlation structure to embed our beliefs that the response would be independent across children, but a child's observations over time would be correlated more strongly when observations were closer in time. To evaluate modeling assumptions, we used residual plots and other appropriate methods which depended on the nature of the model (e.g., testing for validity of a proportional hazards assumption). Because we were concerned about potential collinearity between control variables, we also considered generalized variance inflation factors. Analyses and plotting were completed in R version 4.1.3 (R Core Team, 2022).

Within-County Analysis

In the within-county analysis, we compared eligible children within Lucas and Butler Counties who received services from a CASA volunteer to eligible children in the same counties who did not receive such services. The treatment group consisted of 374 children with eligible legal custody episodes, 32 who were appointed a CASA volunteer from Butler County's CASA program and 342 who were appointed a CASA volunteer from Lucas County's CASA program. The comparison group consisted of 82 children with eligible legal custody episodes who were not appointed a CASA volunteer: 29 children from Butler County and 53 from Lucas County. **Table 4** contains summaries of sample characteristics by treatment group for this analysis.

To account for county-level differences, we included an indicator for county. Because of the small sample size, we were not able to include an interaction between the appointment of a CASA volunteer and race in fitted models.

Table 4. Sample Characteristics for Within-County Analysis

	Comparison (n=82)	**CASA** (n=374)
County (n (%))		
Butler	29 (35.4%)	32 (8.6%)
Lucas	53 (64.6%)	342 (91.4%)
Age in Years (Mean (SD))	5.90 (4.80)	4.26 (4.53%)
Race (n (%))		
White	47 (57.3%)	189 (50.5%)
Black	35 (42.7%)	177 (47.3%)
Other	0 (0.0%)	4 (1.1%)
Unknown	0 (0.0%)	4 (1.1%)
Hispanic (n (%))	0 (0.0%)	2 (0.5%)
Female (n (%))	39 (47.6%)	190 (50.8%)
Prior Intakes (Mean (SD))	1.46 (1.31)	1.15 (1.16)
Prior Out of Home Placements (Mean (SD))	0.63 (2.52)	0.46 (1.36)
Behavioral Health Diagnosis (n (%))		
Child	28 (34.1%)	90 (24.1%)
Mom	40 (48.8%)	186 (49.7%)
Dad	13 (15.9%)	96 (25.7%)
Opportunity Index (Mean (SD))	49.61 (20.62)	54.58 (20.79)
Geographic Isolation (Mean (SD))	4.57 (0.68)	4.62 (0.65)
Tract Percentage POC (Mean (SD))	37.07 (26.34)	43.77 (26.56)

Across-County Analyses

For the across-county analysis, the comparison group consisted of children with an eligible legal custody episode who resided in counties without a CASA program. Two comparison counties without a CASA program were matched to each included CASA county based on population size. We conducted separate county-level analyses for metropolitan and non-metropolitan (rural) counties due to differences in the complexity of their child welfare systems and the diversity of the populations they serve. For the rural county analysis, the treatment group consisted of eligible CASA participants in CASA programs in four non-metropolitan counties, which we refer to as rural counties in this report. To account for the matching of comparison and CASA counties, models in this analysis included indicators for matched counties. **Table 5** contains information regarding the CASA counties considered and their matched comparison counties. Summaries of sample characteristics by treatment group for this rural county analysis are contained in **Table 6.**

Table 5. CASA and Comparison Counties in Rural County Analysis

Comparison County	CASA County
Lake Medina	Butler
Crawford Fulton	Clinton
Knox Washington	Seneca
Licking Trumbull	Summit

Table 6. Sample Characteristics for Rural County Analysis

	Comparison (n=1005)	CASA (n=235)
Age in Years (Mean (SD))	5.83 (5.23)	5.46 (4.94)
Race (n (%))		
White	853 (84.9%)	154 (65.5%)
Black	115 (11.4%)	77 (32.8%)
Other	16 (1.6%)	2 (0.9%)
Unknown	21 (2.1%)	2 (0.9%)
Hispanic (n (%))	0 (0%)	1 (0.4%)
Female (n (%))	509 (50.6%)	116 (49.4%)
Prior Intakes (Mean (SD))	1.35 (1.38)	1.09 (1.36)
Prior Out of Home Placements (Mean (SD))	0.36 (1.30)	1.35 (4.70)
Behavioral Health Diagnosis (n (%))		
Child	299 (29.8%)	74 (31.5%)
Mom	502 (50.0%)	108 (46.0%)
Dad	208 (20.7%)	59 (25.1%)
Opportunity Index (Mean (SD))	75.34 (13.88)	65.98 (15.85)
Geographic Isolation (Mean (SD))	5.67 (1.00)	4.74 (0.63)
Tract Percentage POC	12.21 (16.34)	33.77 (24.90)

We conducted a separate county-level analysis for the CASA program in Franklin County, a large metropolitan county, because metropolitan counties are more complex and serve children from more diverse backgrounds than other counties in Ohio. In this analysis, the treatment group consisted of 246 children with an eligible legal custody episode who participated in Franklin County's CASA program. The comparison group consisted of 1,814 children with eligible legal custody episodes who resided in another metropolitan country and were not appointed a CASA

volunteer. **Table 7** contains summaries of sample characteristics by treatment group for this metropolitan county analysis.

Table 7. Sample Characteristics for Metropolitan County Analysis

	Comparison (n=1814)	**CASA** (n=246)
Age in Years (Mean (SD))	5.93 (5.34)	5.96 (4.53)
Race (n (%))		
White	488 (26.9%)	118 (48.0%)
Black	1264 (69.7%)	126 (51.2%)
Other	27 (1.5%)	1 (0.4%)
Unknown	35 (1.9%)	1 (0.4%)
Hispanic (n (%))	4 (0.2%)	1 (0.4%)
Female (n (%))	899 (49.6%)	133 (54.1%)
Prior Intakes (Mean (SD))	1.35 (1.45)	0.95 (1.12)
Prior Out of Home Placements (Mean (SD))	0.38 (1.23)	0.87 (1.87)
Behavioral Health Diagnosis (n (%))		
Child	543 (29.9%)	73 (29.7%)
Mom	826 (45.5%)	95 (38.6%)
Dad	298 (16.4%)	36 (14.6%)
Opportunity Index (Mean (SD))	55.17 (18.65)	55.21 (21.85)
Geographic Isolation (Mean (SD))	4.21 (0.55)	4.41 (0.96)
Tract Percentage POC	59.18 (32.61)	44.69 (27.52)

Because CASA programs have been identified as a potential strategy to reduce racial disparities that exist in child welfare and health outcomes, our models included an interaction between the indicator for appointment of a CASA volunteer and the indicator for race as part of the across-county analyses. This allowed us to evaluate whether the impact of the appointment of a CASA volunteer on outcomes differs by race. In this analysis, we used two racial categories: (1) a combined Black, Other, and Unknown racial category identified in the results as people of color; and (2) a White racial category.

Results

In this section, we present the results of the within-county and across-county comparisons. As described previously, the methodology accounted for differences in demographic characteristics, prior child welfare involvement, behavioral health, and neighborhood-level social determinants of health (e.g., poverty, education, crime). The sample size for the across-county analysis was sufficiently large to detect even fairly small impacts of the appointment of a CASA volunteer by child's race and geographic region (rural, metropolitan). See **Table 8 for the estimated effects of CASA appointment on each dependent measure.**

Table 8. Estimates of the Effect of CASA Appointment

Outcomes	Within County Analysis	Across County Analysis			
		Rural White	Rural Children of Color	Metropolitan White	Metropolitan Children of Color
Placement Changes	0.921 (0.741, 1.152)	0.987 (0.824, 1.183)	1.125 (0.874, 1.447)	**1.444* (1.181, 1.766)**	**1.635* (1.400, 1.909)**
OOHP	**0.509 (0.401, 0.647)***	**0.821* (0.695, 0.970)**	1.033 (0.798, 1.338)	0.951 (0.811, 1.116)	1.250* (1.061, 1.473)
Re-entry	**0.114 (0.063, 0.205)***	1.118 (0.670, 1.866)	1.551 (0.714, 3.370)	0.841 (0.484, 1.46)	1.393 (0.908, 2.135)
Reunification	**3.871 (1.667, 10.628)***	0.977 (0.642, 1.489)	0.941 (0.473, 1.875)	**0.308* (0.184, 0.515)**	0.959 (0.655, 1.405)
Permanency Placement	**10.02 (4.874, 21.424)***	1.604 (0.838, 3.072)	0.460 (0.167, 1.267)	0.920 (0.458, 1.848)	**0.500* (0.293, 0.852)**
Restrictive Placement[a]	--	0.576 (0.277, 1.196)	0.440 (0.132, 1.474)	0.560 (0.234, 1.338)	**0.258* (0.101, 0.655)**
Timely Well-Child Visits, ≤ 3 Years of Age	1.199 (0.965, 1.504)	1.052 (0.881, 1.257)	1.001 (0.800, 1.253)	1.115 (0.913, 1.362)	1.030 (0.853, 1.243)
Timely Well-Child Visits, > 3 Years of Age	0.830 (0.661, 1.046)	1.171 (0.995, 1.379)	0.972 (0.729, 1.297)	**1.310* (1.086, 1.579)**	**1.369* (1.167, 1.605)**
Preventable ED Visits	0.915 (0.761, 1.106)	**1.334* (1.161, 1.533)**	**1.789* (1.467, 2.183)**	**0.819* (0.699, 0.96)**	**0.576* (0.486, 0.684)**

See Table 2 for definitions of outcome measures
Table values represent relative risk estimates and 95% confidence intervals.
Statistical significance denoted by bold numerals and *
[a] Analysis of Restrictive Placement focused on children with behavioral health diagnoses.

Placement Changes

The within-county analysis revealed no difference in the rate of placement changes among children who were appointed a CASA volunteer compared to children in the same counties who were not appointed a CASA volunteer. The across-county analysis revealed a significant effect in metropolitan counties – ***in metropolitan counties, we estimated that the average child appointed a CASA volunteer will experience a higher number of placement changes than the average child from the comparison county without a CASA program*** *(see* **Figure 1***)***.** Holding all else constant, White children who were appointed a CASA volunteer experienced placement changes at a rate 1.44 times higher (i.e., 1.11 / 0.77) than White children who were not appointed a CASA volunteer. Similarly, children of color who were appointed a CASA volunteer experienced placement changes at a rate 1.64 times (1.44 / 0.88) that of similar children of color who were not appointed a CASA volunteer. No difference was observed in rural counties between children who were appointed a CASA volunteer and a comparison group of children

from counties without a CASA program (figure not shown). These findings were similar among White children and children of color.

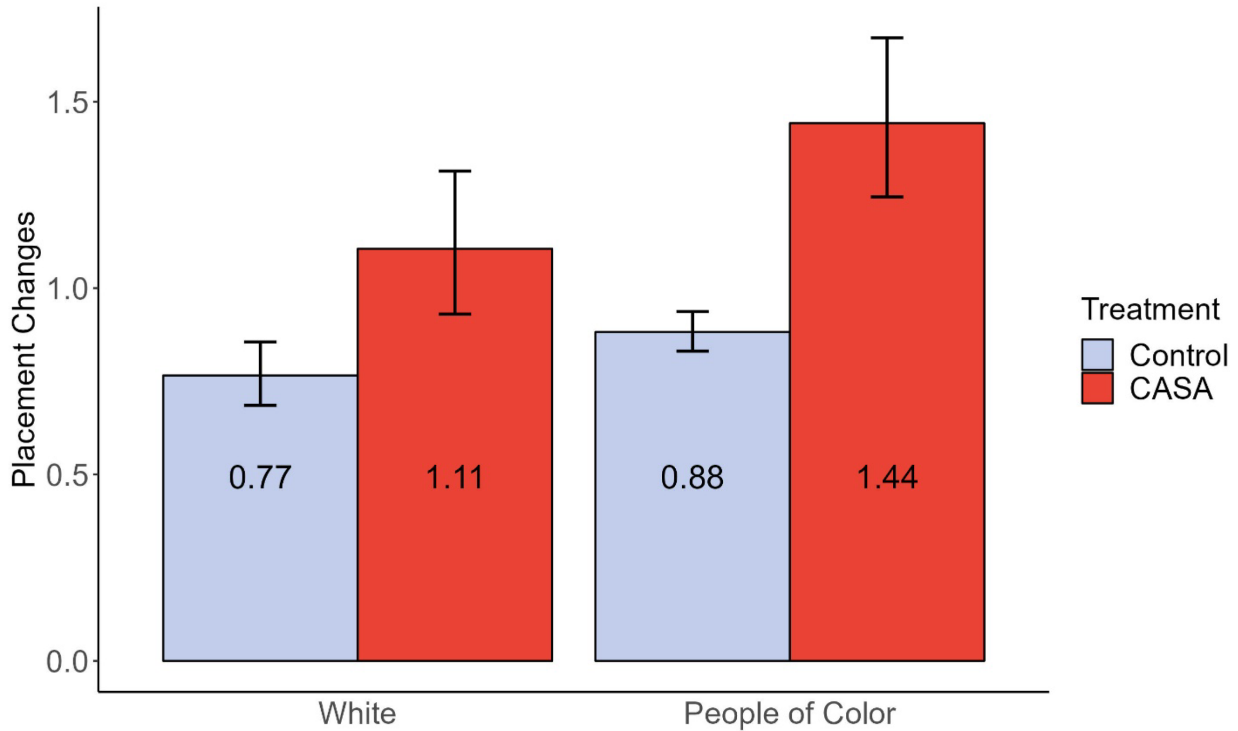

Figure 1: Predicted Number of Placement Changes per Legal Custody Episode - by CASA Volunteer Appointment and Race/Ethnicity (Metropolitan County Analysis)

Time in Out-of-Home Placement

The within county analysis revealed that appointed a CASA volunteer was associated with substantially less time spent in OOHP. Holding all else constant, the results suggest that a child who is appointed a CASA volunteer has 0.51 times the odds of OOHP as a child in the same county who is not appointed a CASA volunteer (see **Figure 2**).

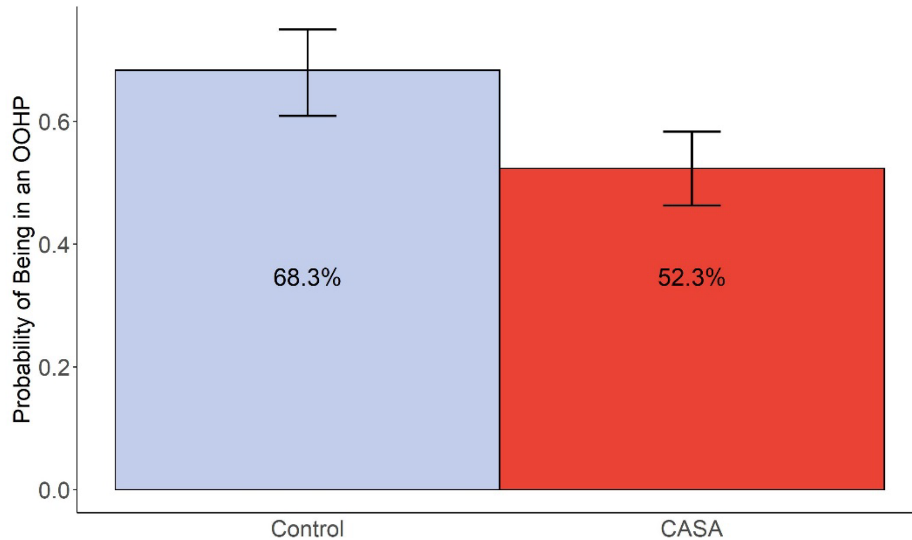

Figure 2: Probability of Remaining in OOHP at Any Point in Time After Start of Legal Custody Episode - by CASA Volunteer Appointment (Within-County Analysis).

The results of the across-county analysis differed by race and geography. In rural counties, the appointment of a CASA volunteer was associated with a reduction in the amount of time in OOHP for White children, but not children of color (see **Figure 3**). White children in rural counties who were appointed a CASA volunteer had 18% lower odds of remaining in OOHP at any given point in time after the initial placement date than similar White children who were not appointed a CASA volunteer. ***In metropolitan counties, the appointment of a CASA volunteer was associated with an increase in the amount of time in OOHP for children of color, while no effect was observed among White children*** (see **Figure 4**)**.** For children of color in metropolitan counties, appointment of a CASA volunteer was associated with 25% greater odds of remaining an OOHP at any given point in time compared to similar children of color who were not appointed a CASA volunteer.

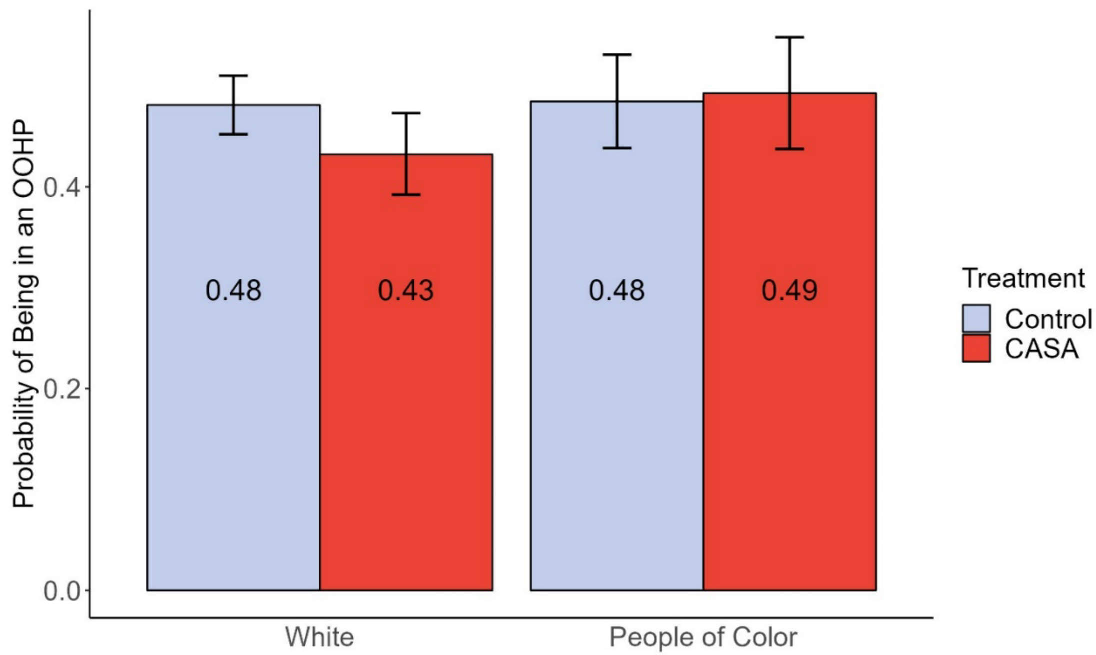

Figure 3: Probability of Remaining in OOHP at Any Point in Time After Start of Legal Custody Episode - by CASA Volunteer Appointment and Race/Ethnicity (Rural County Analysis)

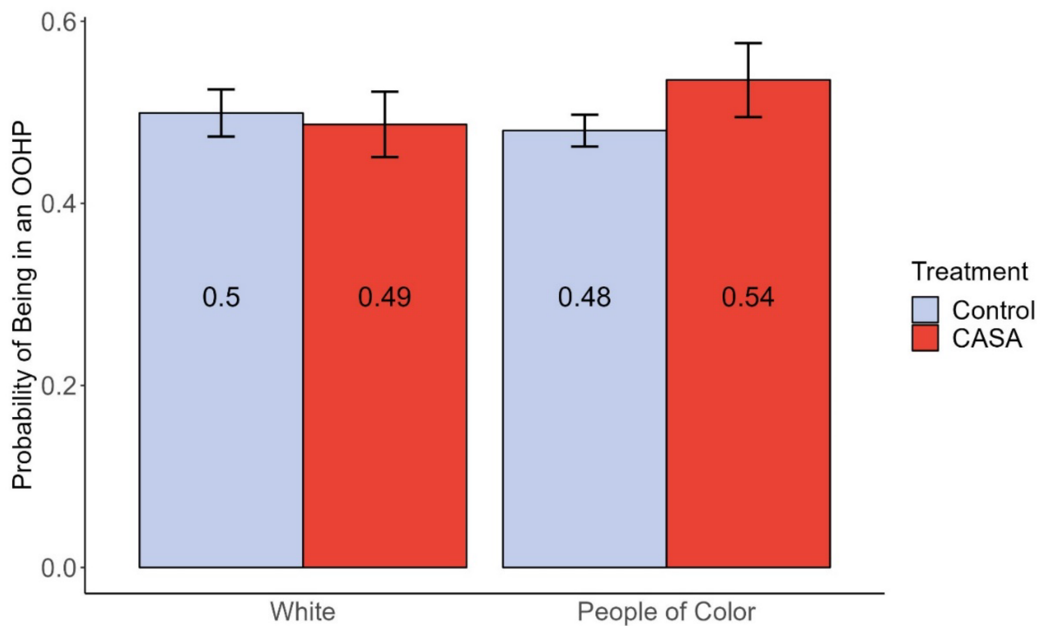

Figure 4: Probability of Remaining in OOHP at Any Point in Time After Start of Legal Custody - by CASA Volunteer Appointment and Race/Ethnicity (Metropolitan County Analysis).

Re-Entry into Out-of-Home Placement

We observe a significant relationship between the appointment of a CASA volunteer and re-entry into an OOHP after discharge – ***the average child who was appointed a CASA volunteer was less likely to re-enter within one year of discharge than the average child who was not appointed a CASA volunteer*** (see **Figure 5**). Based on this analysis, we predict that children who are appointed a CASA volunteer have a risk of re-entry that is 0.11 times the risk of children who are not appointed a CASA volunteer. In contrast, the across-county analysis, did not identify a significant association between appointment of a CASA volunteer and the risk of re-entry into an OOHP in either rural or metropolitan counties.

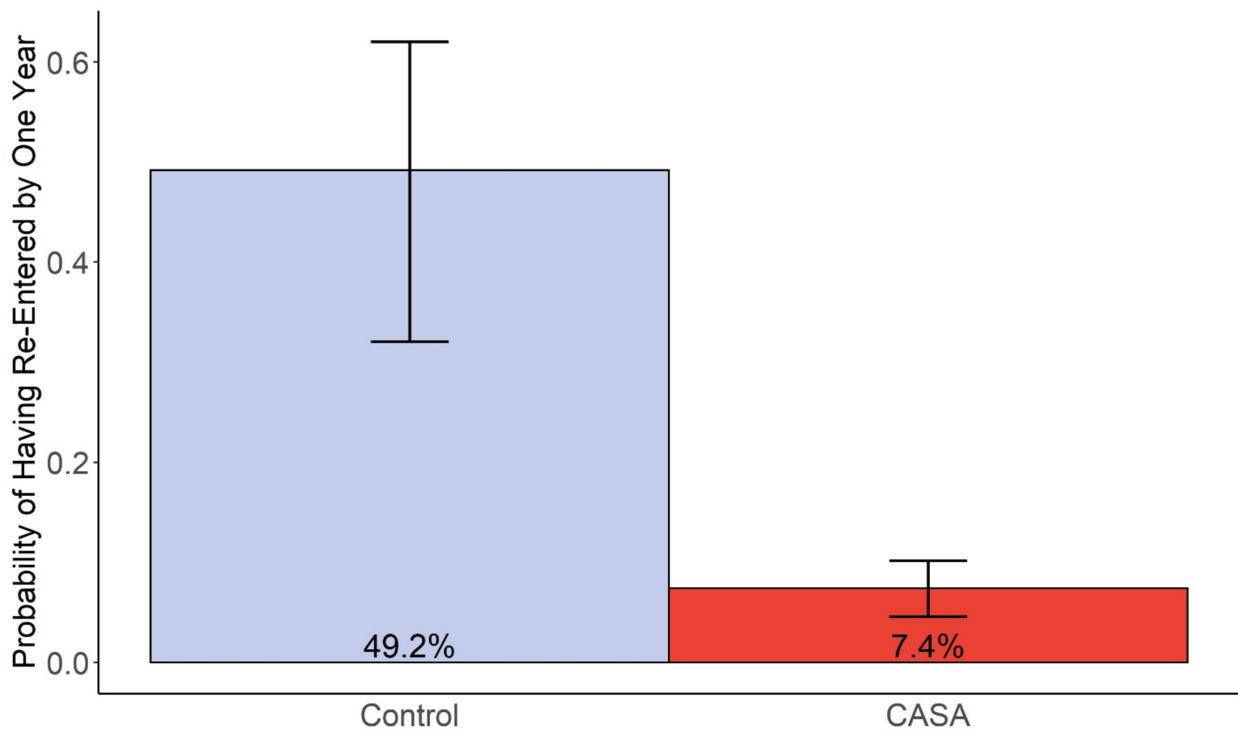

Figure 5: Probability of Re-Entered into an OOHP Within One Year of Discharge - by CASA Volunteer Appointment (Within-County Analyses).

Reunification with Family

The results of the within-county comparison suggested that the average child who was appointed a CASA volunteer was more likely to experience reunification with family upon discharge than the average child who was not appointed a CASA volunteer (see **Figure 6**)**.** *The odds of reunification for a child who was appointed a CASA volunteer was 3.87 times the odds of reunification for a child who was not appointed a CASA volunteer.*

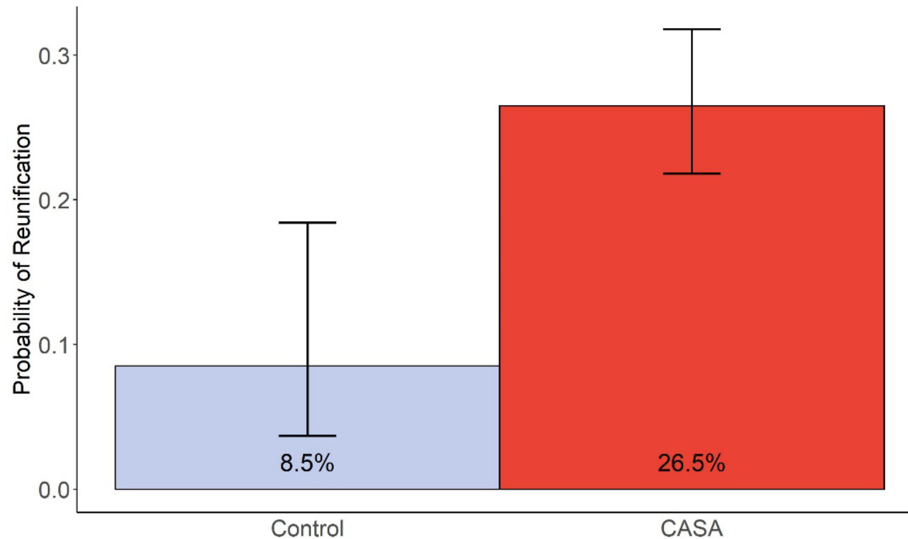

Figure 6: Probability of Reunification with Family upon Discharge – by CASA Volunteer Appointment (Within-County Analysis)

The results of the across-county comparison revealed no association between appointment of a CASA volunteer and the probability of reunification with family upon discharge, with one exception: ***in metropolitan counties, the probability of reunification for a White child who was appointed a CASA volunteer was lower than for a White child who was not appointed a CASA volunteer*** (see **Figure 7**)**.**

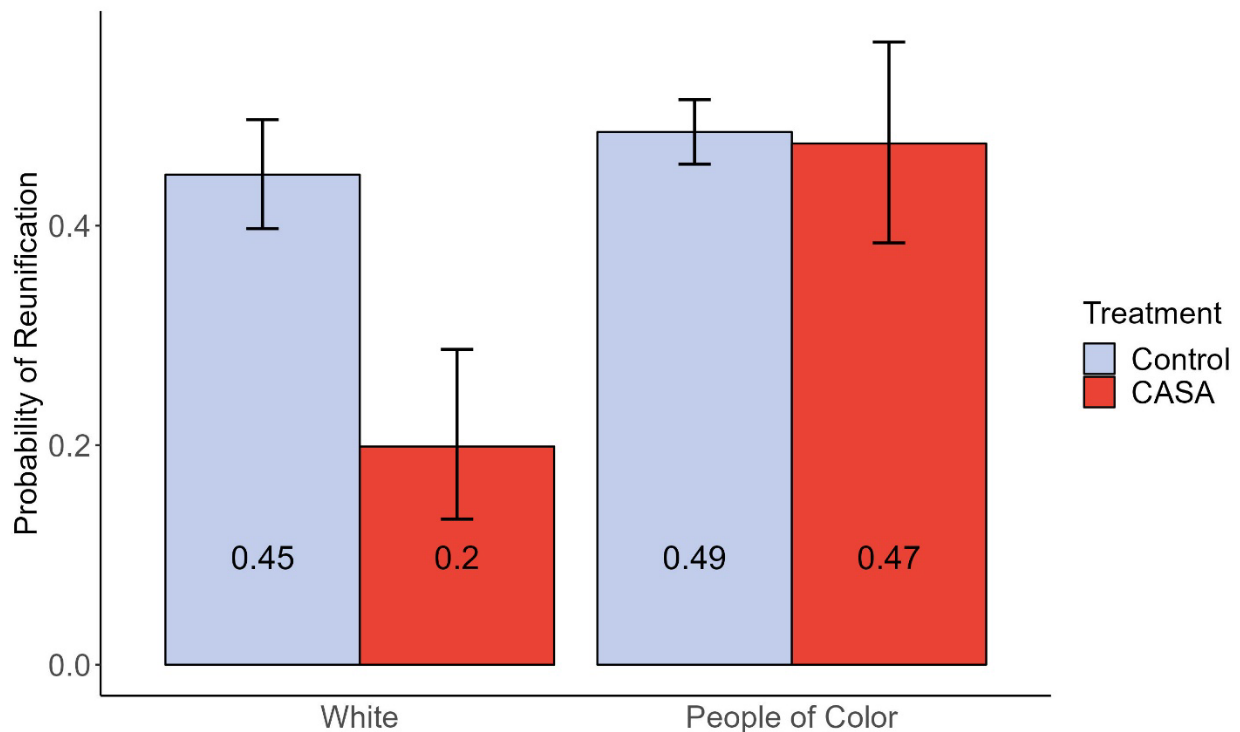

Figure 7: Probability of Reunification with Family upon Discharge – by CASA Volunteer Appointment and Race/Ethnicity (Metropolitan County Analysis).

Permanency Placement

The results of the within-county analysis suggest that there was a significant relationship between the appointment of a CASA volunteer and the likelihood of a permanency placement upon discharge. ***Holding all else constant, the odds of a permanent placement upon discharge was 10.02 times greater for a child who was appointed a CASA volunteer compared to a similar child who was not appointed a CASA volunteer*** (see ***Figure 8***)**.** In contrast, the across-county analysis identified no relationship between the appointment of a CASA volunteer and the odds of a permanent placement upon discharge in either rural or metropolitan counties.

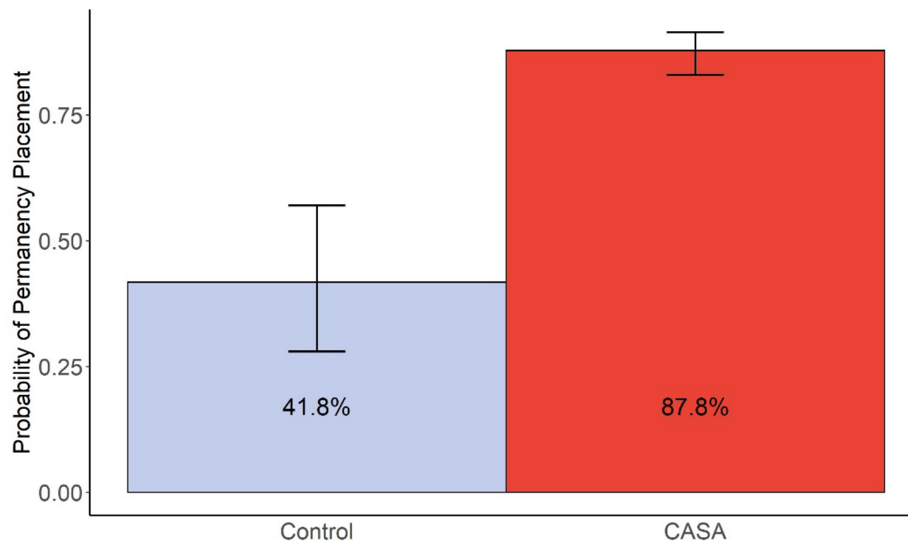

Figure 8: Probability of a Permanency Placement upon Discharge – by CASA Volunteer Appointment (Within-County Analysis).

Time in Restrictive Placement

The number of children who were placed in a restrictive placement setting was too low to estimate the effect of CASA assignment in the within-county comparison analysis and no significant effects were observed among White children and children of color in the across county analyses. However, in a follow-up analysis in which we combined both racial groups in the across-county analysis (to increase statistical power), we observed that ***the appointment of a CASA volunteer was associated with a reduction in the amount of time that children with behavioral health diagnoses spent in restrictive placements.***

Timely Well-Child Visits

The within-county comparison revealed no significant association between the appointment of a CASA volunteer and the rate of timely well-child visits for children ages three and under or over age three. However, ***results of the across-county analyses suggested that appointment of a CASA volunteer in metropolitan counties was associated with a higher rate of timely well-child visits among children over age three*** (see **Figure 9**). In metropolitan counties, White children who were appointed a CASA volunteer had a rate of timely well-child visits that was 1.31 times greater than that of similar White children who were not appointed a CASA volunteer. For children of color who were appointed a CASA volunteer, the rate of timely well-child visits was 1.37 times greater than that of similar children of color who were not appointed a CASA volunteer. We observed no association between appointment of a CASA volunteer and the rate of well-child visits for children in rural counties or children ages three and under.

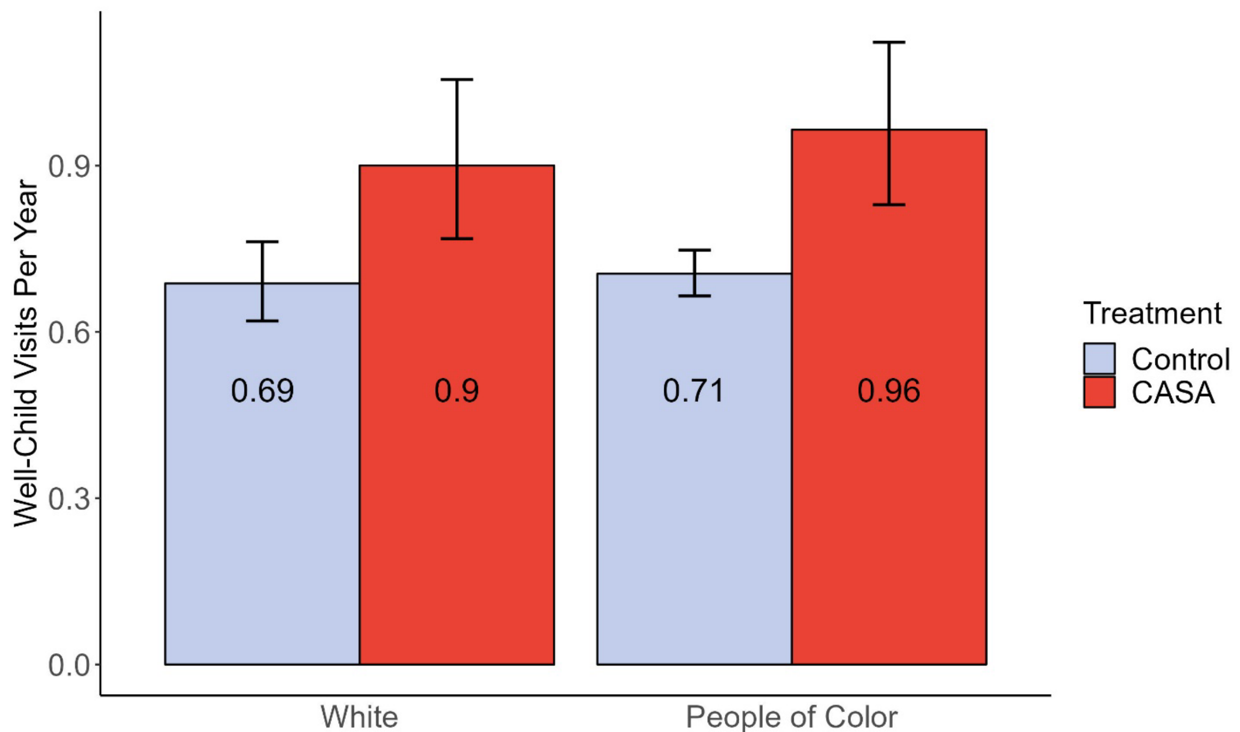

Figure 9: Number of Well-Child Visits per Year for Children Greater than Three Years of Age – by CASA Volunteer Appointment and Race/Ethnicity (Metropolitan County Analysis)

Preventable Emergency Room Visits

The within-county comparison revealed no significant association between the appointment of a CASA volunteer and the rate of preventable emergency room visits. However, the across-county analysis revealed that, ***in rural counties, the appointment of a CASA volunteer was associated with a higher rate of preventable emergency room visits among both White children and children of color.*** White children who are appointed a CASA volunteer had preventable emergency room visits at a rate 1.33 times that of similar White children who did not have a CASA volunteer. Children of color who were appointed a CASA volunteer had preventable emergency room visits at a rate 1.79 times that of similar children of color who were not appointed a CASA volunteer. Furthermore, the difference between the effect of the appointment of a CASA volunteer among White children and children of color was statistically significant (see **Figure 10).**

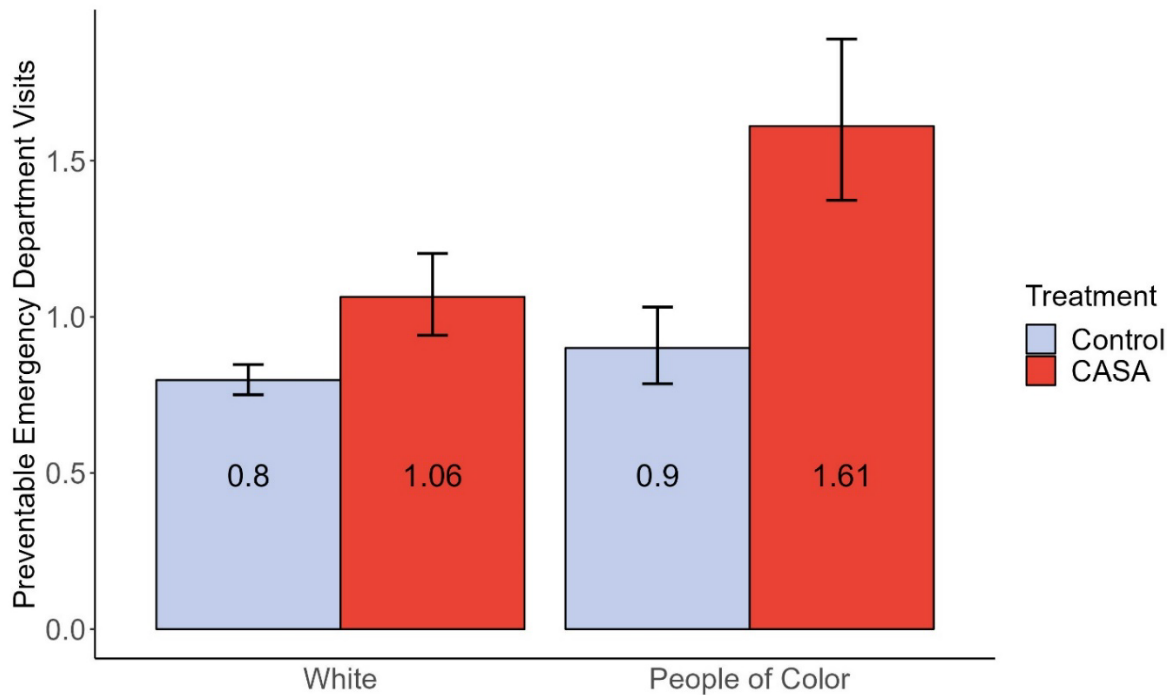

Figure 10: Number of Preventable Emergency Department Visits per Year - by CASA Volunteer Appointment and Race/Ethnicity (Rural County Analysis).

***In the metropolitan county analysis, the appointment of a CASA volunteer was associated with a lower rate of preventable emergency room visits among both White children and children of color, the opposite of the pattern we saw in the rural county analysis*.** White children who were appointed a CASA volunteer had preventable emergency room visits at a rate 0.82 times that of a similar White child without a CASA volunteer. Child of color who were appointed CASA volunteers had preventable emergency room visits at a rate 0.58 times that of similar children of color without a CASA volunteer. Again, the difference between the effect of the appointment of a CASA volunteer among White children and children of color was statistically significant (see **Figure 11**)

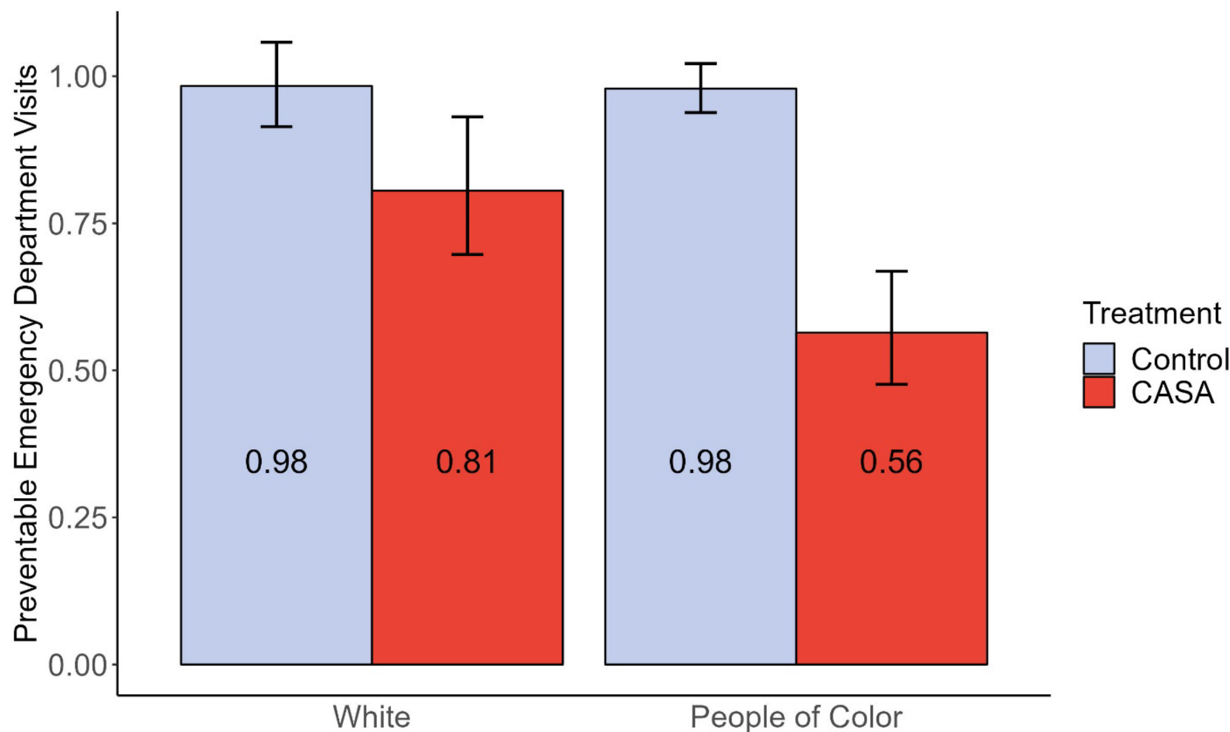

Figure 11: Number of Preventable Emergency Department Visits per Year - by CASA Volunteer Appointment and Race/Ethnicity (Metropolitan County Analysis).

Discussion

This study sought to evaluate whether CASA programs in Ohio were effective at improving the experiences of children in the child welfare system. As the GRC interpreted the study's findings, the team was mindful of the vulnerability of children who appear in Ohio's juvenile court as a result of abuse, neglect, or dependency. These young people have experienced significant challenges. The CASA program's goal is to provide them with a safe, permanent home and the chance to thrive. The ramifications of the CASA program's effectiveness clearly begin with the immediate and long-term well-being of each individual child, but they also extend to the future of our communities, our state, and the nation. With those profound implications underpinning GRC's study, we summarize our insights below.

What is the impact of CASA on children's experiences in the child welfare system?

The study identified several differences between children who were assigned a CASA volunteer and those who were not. Overall, young people who were assigned a CASA volunteer spent less time in OOHP, were less likely to re-enter OOHP following discharge, and more likely to be

reunified or enter a permanent placement compared to young people in the same counties who were not assigned a CASA volunteer. Young people who were assigned a CASA volunteer experienced more placement changes and spent less time in restrictive placements than their counterparts in counties without a CASA program.

While our finding of increased placement changes, taken in isolation, might suggest instability for kids, the finding that children who have been appointed a CASA volunteer spent less time in a restrictive placement suggests those changes were less likely to be based on behavioral issues and were perhaps reflective of CASA volunteers facilitating placements that better matched children's needs and preferences. Further, appointment of CASA volunteers correlated with a reduction in the total amount of time children spent placed out of the home, and this could also be the result of a more appropriate placement experience.

What is the impact of CASA on children's health care?

There was evidence that children older than three who were assigned a CASA volunteer received more maintenance-oriented medical well-child visits—a significant, positive benefit for children's long-term health. Notably, it appears as though the appointment of a CASA volunteer brought these children nearly up to the recommended rate of one visit per year.

Does the impact of CASA differ by geography and race?

There were several important differences related to geography – in metropolitan areas, assignment of a CASA volunteer was associated with more placement changes, more timely well-child visits, and a lower rate of preventable emergency room visits. In contrast, CASA assignment in rural areas was associated with a higher rate of preventable emergency room visits.

One explanation for the geographic difference in the impact of CASA on preventable emergency room visits may be that access to preventive care is more limited in rural settings. Workforce constraints and travel barriers lead many families to seek care in emergency rooms for conditions that could otherwise be treated in a primary care setting. Thus, an increase in preventable emergency room visits may indicate that CASA volunteers are encouraging families to seek treatment for their children's health care needs, regardless of the setting.

Overall, there were several areas where the impact of CASA differed by race *and* geography. Appointment of a CASA volunteer was associated with less time in OOHP for White children in rural areas, but not children of color. In metropolitan areas children of color experienced an increase in time in OOHP. In rural areas, the association between CASA assignment and visits to an emergency room for nonemergent conditions was greater among children of color than among White children. We saw mixed findings regarding reunification and permanency

placement following an OOHP in metropolitan counties – with the lowest rate of reunification observed among White children in the metropolitan CASA program.

Limitations and Conclusion

This study design took steps beyond previous studies by accounting for additional factors that could otherwise confound the results. The design was facilitated through access to important information about children and families that can be found in medical claims records (e.g., geographic location of residence and behavioral health diagnoses) and child welfare databases (e.g., histories of child welfare involvement). Because of this, we believe our estimates of the association between CASA involvement and child outcomes are closer to causal estimates than in previous studies. However, despite this added information, we suspect we still were unable to measure some important characteristics of children and families (e.g., parental education and involvement in the criminal justice system) and county resources (e.g., funding, nearby facilities) that could explain the inferred effects of the appointment of a CASA volunteer. Thus, we encourage caution with the interpretation of the reported findings. With some exceptions, we conclude that the findings are suggestive of a positive impact of the appointment of a CASA volunteer on the experiences of children in the child welfare system and in their utilization of health care.

References

Abramson, S. (1991). Use of court-appointed advocates to assist in permanency planning for minority children. *Child Welfare: Journal of Policy, Practice, and Program*, *70*(4), 477–487.

Billings, J., Parikh, N., & Mijanovich, T. (2012). Emergency room use: The New York story. 2000. *New York: The Commonw Fund*.

Birks, M., & Mills, J. (2015). *Grounded Theory: A Practical Guide*. SAGE.

Caliber Associates. (2004). *Evaluation of CASA representation: Final Report*. https://ocfs.ny.gov/main/recc/documents/Caliber-CASA-Study-Summary.pdf

Calkins, C. A., & Millar, M. (1999). The Effectiveness of Court Appointed Special Advocates to Assist in Permanency Planning. *Child and Adolescent Social Work Journal*, *16*(1), 37–45. https://doi.org/10.1023/A:1022213722580

Miller, J. M., & Miller, H. V. (2015). Rethinking Program Fidelity for Criminal Justice. *Criminology & Public Policy*, *14*(2), 339–349. https://doi.org/10.1111/1745-9133.12138

Poertner, J., & Press, A. (1990). Who Best Represents the Interests of the Child in Court? *Child Welfare*, *69*(6), 537–549.

Powell, M., & Speshock, V. (1996). Arizona Court Appointed Special Advocate (CASA) program. *Internal Assessment*.

Stewart, D., Shamdasani, P., & Rook, D. (2009). Group Depth Interviews: Focus Group Research. In L. Bickman & D. Rog, *The SAGE Handbook of Applied Social Research Methods* (pp. 589–616). SAGE Publications, Inc. https://doi.org/10.4135/9781483348858.n18

Waxman, H. C., Houston, W. R., Profilet, S. M., & Sanchez, B. (2009). The Long-Term Effects of the Houston Child Advocates, Inc., Program on Children and Family Outcomes. *Child Welfare*, *88*(6), 25–48.

Part 2: Qualitative Report

Introduction

Children who are removed from their home as a result of abuse, neglect, or dependency face a range of challenges that vary depending on age and individual circumstances. Being removed from their home and placed in the care of strangers is traumatic for children, particularly if they have experienced abuse, neglect, or other forms of maltreatment in their family. Their education and social connections are often disrupted; they are frequently separated from siblings, friends, and other family members. They are likely to experience uncertainty about their foster care arrangements, reunification with their families, and potential adoption. The lack of control in their personal lives can be compounded by the outcomes of legal proceedings they may not understand, and help in understanding often is incomplete or entirely absent. Decisions about the lives and futures of these children frequently are made without the child's input, despite having long-term consequences for developmental well-being and furthering their feeling of lack of control. Even under the best of circumstances, many individuals who work and volunteer within the system have limited training in evidence-based practices and childhood development (Arredondo, 2003:13).

The results from Part 1 of this report suggest that appointment of a CASA volunteer is associated with modest improvement in placement-related outcomes (e.g., less time spend in restrictive placements, less likely to reenter foster care) and health care utilization (timelier child-well visits).

The current study focuses on information gathered from individuals with lived experience in foster care and with the support and advocacy of adults in the courts. The goal of this study is to better understand how adults can advocate and support children while they are in the foster care system and identify areas of training that should be prioritized in order to ensure that CASA volunteers and others who serve these children are sufficiently knowledgeable and prepared for their role. These young people have first-hand knowledge of the child welfare system and provide valuable insights into the strengths and weaknesses of the system. Their perspectives are intended to help improve the advocacy and support that CASA volunteers provide to youth to ensure that their needs are met. Their perspectives are essential to shaping policy and helping policymakers and other stakeholders to better understand the needs of children in foster care.

Methodology

Data source

Two focus groups were conducted with young adults who had prior experience in foster care. Purposive sampling was used to recruit participants from the Columbus State Scholar Network (CSSN), a program to provide students who have a history in foster care with peer support and academic mentoring to succeed in college. A total of 21 students participated in the two focus groups. Focus groups were conducted in person at Columbus State Community College on March 22, 2023.

The majority of participants (16 out of 21) were between 18 and 24 years of age; five participants were over 24 years of age. Two participants had one or more CASA volunteers assigned to them while in the child welfare system. Nine participants had an attorney GAL. Eleven participants were unaware of having either a CASA volunteer nor an attorney GAL assigned to them, or were uncertain whether they had a CASA volunteer and/or an attorney GAL assigned to them.

Focus group interview questions were developed with input from the Overcoming Hurdles in Ohio Youth Advisory Board (OHIO YAB), a group of young leaders who experienced custody through the child welfare system. The questions were designed to elicit information about participants' experiences related to:

1. Describing the types of help and support needed from adults assigned to assist them when in foster care. What supports were most beneficial to them while they were in the system?

2. Whether their needs were met during their time involved with the child welfare system. Whether their needs were understood and considered by the people assigned to represent them while in the child welfare system. How (if at all) were their needs taken into consideration?

3. Describing the impact of having or not having needs understood, considered, or met during involvement in the child welfare system. How could better support from adults help during child welfare involvement?

Participants were provided with paper and pens and were invited to jot down notes and brainstorm their thoughts and reactions to each question before responding. A semi-structured focus group protocol guided the discussion (See Appendix A). Focus groups lasted one hour, and each participant received a $50 Visa gift card for their participation. This study was reviewed and approved by the Institutional Review Board at Ohio State University.

Analytic methods

We used a multi-stage approach to qualitative coding. Focus group sessions were recorded and transcribed, and transcripts were uploaded to ATLAS.ti for content analysis. Written notes from the focus groups were generated from the four co-facilitators and were read multiple times to begin the process of getting a better sense of what was shared and identifying themes and issues that emerged. We used a multiple coding approach in which passages of text could be categorized with one or more relevant codes. The project team generated a coding frame through a combination of deductive (notes from the focus groups) and inductive methods that included generation of an initial set of theme codes based on literature review and initial observations and notes taken from the focus groups.

In order to identify prominent themes, we leveraged the subject matter and the policy and practice expertise of our coding team, which included a PhD developmental psychologist, an urban sociologist who researches health disparities, and a social worker with personal experience in foster care as well as professional experience in the child welfare system. The research team engaged in multiple discussions and memo-writing while the focus group discussions were being transcribed and independently considered the experiences of the focus groups within the context of prior research and their triangulated expertise.

A longer set of themes guided the stages of open to axial (organized) coding within the Atlas.ti software (Berg and Lune 2016). Coding was then conducted independently by two team members who each served as the lead coder for one transcript, and then served as the secondary coder for the second transcript. The team met weekly for informal intercoder comparisons and discussions so that the initial lists of prominent themes could then be reviewed. This was followed by additional refinement of the coding frame.

The team developed a total of sixteen (16) overarching themes that were then clustered into related categories of meaning and highlighted emergent patterns in the data. These patterns were grouped into three (3) major categories (see **Table 1**). The team reviewed code densities, co-occurrences, and relationships between topics, and generated reports in ATLAS.ti to assess patterns emerging in the data. Some themes were relevant to more than one category; for example, supporting the transition from foster care to independent living was identified as both a need and a best practice.

Table 1. Categories of overarching themes and densities

Categories	Major themes (count of mentions in focus group #1, #2)
1. Challenges youth experienced that required adult support.	1.1 Advocate for legal rights and basic resource needs (17, 11)
	1.2 Assure safety and protection (4, 16)
	1.3 Represent child's interests in healthcare decisions (15, 7)
	1.4 Assure that children have a voice in court proceedings and decisions about their placement and contact with family (17, 0)
	1.5 Believe and act upon children's reports of abuse (7, 3)
	1.6 Support transition from foster care to independent living (2, 6)
2. The impact of not having adult support to meet needs.	2.1 Being "othered" by adults responsible for care (3, 8)
	2.2 Feeling powerless regarding healthcare decisions (6, 6)
	2.3 Feeling exploited for income (7, 11)
	2.4 Experiencing stress and trauma without support (0, 8)
3. Best practices for adults assigned to represent youth.	3.1 Provide emotional support to address past trauma (24, 5)
	3.2 Build skills for independent living (11, 7)
	3.3 Value youth perspective; support self-determination by providing a voice (9, 10)
	3.4 Invest in relationships between youth and adult advocates (12, 7)
	3.5 Reinforce adults' accountability for youth outcomes (3, 15)
	3.6 Respect for diverse cultural backgrounds (7, 9)

Results

Participants' perspectives about the adult support for youth in foster care were grouped into 16 themes that were sorted into three categories: (1) Areas where help and support from adults was needed while in the child welfare system (challenges); (2) The impact of having support needs unmet; (3) Best practices for adults assigned to advocate for youth in foster care, including areas where additional training may be provided to adults to more effectively address challenges faced by youth in the child welfare system. This report includes a description of each category of response, key themes within each category, and examples of responses that illustrate each theme.

1. Challenges youth experienced that required adult support

Youth described challenges they experienced while in the child welfare system that could be minimized with support from adults assigned to advocate for them. Six major themes emerged from their responses (see **Table 1**). For the most part, challenges were experienced as unmet needs for protection, support, and having a voice regarding their care.

1.1 Advocate for legal rights and basic resource needs (17, 11 mentions)

Participants reported needing advocates to assure that their basic needs were being met and that they could be protected from parents or guardians who were potentially abusive or unfit to care for them. Several participants reported being unable to receive services that they were directed to receive, such as educational support, financial resources for clothing and other basic necessities, or transportation.

> *I was given a voucher, but never was given the [chance] to go and to get the stuff… They said the reason why I couldn't get it was because I was always in trouble there. So, they were like, "We can't take you out or out of the premises of the unit." So I was like, 'Okay. How am I, when am I going to get the clothes, though?*

The lack of control many reported experiencing came in several forms, including those detailed in *Category 2: The impact of not having adult support to meet needs* (see below). Here, that lack of control over their well-being was described in anecdotal stories of parents and custodians who did not act in the child's best interest.

> *Recommendations that were made, like me to get an I.E.P. Or maybe to start medication, or like family therapy. And none of that happened because my mother, she's kind of a conspiracy theorist…. So I didn't get any of that help that I needed.*

> *I would always try to tell them, like, 'Pull up the regulations of where that money was supposed to be allocated.' And they'd be like 'We don't care.' They gave me none of [the money that was intended for me from social security] … and I was like 'Where is it going?' and they basically just explained that we're paying the whole rent with it and I was like "I need school clothes, and everything else, and like, hygienic products and stuff like that."*

> *I just remember when we would move from home to home, like all our stuff would be lost and I would ask my caseworker, hey where is- something as simple as clothes. We have to go to school. What am I going to wear? Or something like, I remember her bunny or something. Things that are sentimental to you. Things that you need. And nothing would happen. Nothing would get done.*

1.2 Assure safety and protection from abuse (4, 16 mentions)

Participants reported needing protection for basic safety concerns. This included assuring that the adults who were caring for them were being appropriately supported and monitored and that their living situation was safe. Some participants reported overcrowding and abuse at the hands of other children. Other participants reported needing advocates to intervene and stop caretakers who were abusive.

We had three girls in one room, three boys in another room, and two girls over here, and I don't know. It was just a lot of bullying. A lot of fighting going on. Stealing. Never had a nice thing. Everything that was given to me was stolen.

Um, and when I was eight, she decided that she wanted to send me to another country. And no one intervened. She was just like, "You're going to go to this other country." She just like, shipped me away. I wish that there were people, or someone who had a little bit more involvement and a little bit more authority to be like, you know, this is not a safe place for you to be. I don't know, I feel like I was just left with her.

The limited presence of protections from abuse came in many forms. These included few, and/or irregular assessments of how the child in care was doing, and/or priority and latitude being given to individuals responsible for ensuring child well-being while the children in care felt endangered.

They don't check back in when you're with your parents.

I wish someone else had power to intervene, or could almost, like veto my mother's authority. Because my mom was not a fit caretaker and I feel like there's only so much that other people can do.

And even when we were saying stuff to the social workers, and when we would go visit our dad on the one-hour visitations or whatever, they still were like, "Well we don't want to take you out of the home because this is the only person that will keep you guys together. It was more of keeping us together than it was for our safety, for our well-being and stuff. And yeah, it's like there should have been someone there to be an advocate for us.

1.3 Represent child's interests in healthcare decisions (15, 7 mentions)

Participants also described needing an adult to represent their interests in decisions regarding their treatment for health conditions, including mental health. Several participants reported being unable to obtain adequate care. Some reported being pressured to take medication against their will, while other participants described being prevented from taking medications that had been prescribed to them or not being allowed to participate in counseling that was needed or had been arranged for them by a professional.

I have very bad ADHD but I was always told that it didn't exist because my grandparents never….it just doesn't exist to them.

They didn't know I was diabetic at the time…they didn't send me to the hospital or anything until it got really bad and then when I came back they were like well your

insurance doesn't pay for insulin so you're just going to have to eat like 20 carbs a day and drink a bunch of water and I was like "Oh ok yeah, that's a great…" so but eventually I got a new caseworker and they did something about it and got me different insurance, but that is a big thing, healthcare and insurance.

It did not feel like taking psych meds were actually a choice, and the amount of like overmedication like when I – there are multiple doses that I was on for extended period … Here's the thing, if you refuse your meds: there was like a system, there were 4 levels. There was orientation, learner achievement, and success and like refusing your meds was grounds to drop you a level because you're not complying with your treatment. So then if you're getting dropped a level, that means you don't get to talk to your parents as long, you wouldn't talk to your family as long, you don't get like access to your like, Ramens and candy and stuff if you were able to buy any, you can't get that then. So like sure, you have the right to refuse but do you really then, if your privileges are being taken away?

1.4 Assure children have a voice in court proceedings, decisions about their placement, and decisions about contact with family members (17, 0 mentions)

A common challenge described by participants was not having the opportunity to be involved in decisions about their placements. Participants described not being informed about reason for their removal from home, and not being provided with information in advance of placement changes. They also described having little input into decisions about the amount of contact they would have with their family.

They just don't explain things. It's like you're moving the next week, you know. We found a home for you, you're moving.

It's like I didn't really know what was going on, so it just felt like it wasn't really justified taking me out of the home…And I was 7, it's not like I couldn't understand anything. It left me kind of blaming myself because at that point you can only blame others or yourself. It kind of made me like have less confidence in myself as I really should have … it's hard to have a voice if you don't know the facts of the matter.

My guardian ad litem did not listen to me. I know he was supposed to be my advocate. I would tell him … my dad scares me and he'd be like, "But have you tried talking to him?" Literally that was his response to everything, but have you tried talking to him? I'm like yeah, I lived with him for 12 years. You would think that the problems would have been solved by then if he was willing to work it out, but no, that's why I'm here. That's why I'm trying to get away from him. And he wouldn't listen.

1.5 Believe and act upon reports of abuse (7, 3 mentions)

Many participants described having no adult who believed them or acted on their reports of abuse. Many respondents described how they wished that adults would have protected them when they were reporting abuse or being at great risk of abuse. Worse yet, for some, this lack of support included being coached to cover up abuse or turning around their reports of abuse to be their fault. Several respondents also described feeling like they could not report abuse without facing repercussions.

> *They had someone from (the children services agency) come out. But they were like "Yeah you're fine." Like they didn't see any issues at all. …. And like, obviously, my stepmom just tried to kill herself, that's a big problem. And they didn't do anything after that, so I don't know exactly what conversations happened… I remember being visibly upset trying to talk to the caseworker. Like please listen to me, and they, they didn't do anything.*

> *My sister tried to attempt also, and a caseworker never came, like-… her antidepressants were then taken from her … and flushed down the toilet, like, "You don't need meds, you're fine." Got rid of her therapy and everything … a caseworker would have noticed these things if they ever actually came and checked, but that never happened …*

With vulnerable children, the lack of concern and inaction from adults can be especially harmful. Perhaps worse yet is not being believed. Multiple respondents stated that they experienced this reaction from adults with whom they thought they had developed a trust, however fragile. Conversely, for some participants, reporting abuse could potentially cause it to escalate. As two respondents noted:

> *Oftentimes when we do speak up about it, the foster parents either turn it on the youth, or are able to convince the case manager, or the caseworkers that the youth are lying, or it just never gets investigated at all.*

> *I remember my mom being like, if people would come to the house, there was a lot of coaching, a lot of threats. So sometimes, like, if there was intervention, I don't know if I was able to, I don't know, tell them. I don't know, 'cause you know what's going to happen when they leave. I just wish someone had more power than my mom, because she was not a fit mom.*

1.6 Support to transition from foster care to independent living (2, 6 mentions).

Participants described needing more help and support to transition from care to independent living. While there are educational programs available to help youth get ready to live on their own, many youths do not participate. Some respondents described being discouraged from participating. Other respondents reported that they were told about the training, but the importance of the training was not conveyed to them, and they didn't attend.

I kind of pushed aside the independent living conversation and didn't let them enroll me in classes. I kind of regret that now. Like aging out, I just needed independent living skills like hands-on skills like cooking, budgeting, driving.

Caseworkers don't realize how important they are and being a champion for them. … versus, "Hey, I signed you up," and then leave it up to the foster parents to get you there, and don't really check in around it. Those were two different type of messages. One of them is like, "Yo, this is very important, you need this, this is going to set you up," and the other one is like, "You know, it could help you, or whatever." I feel like the presentation could be better, it could be stronger.

2. The impact of not having adult support to meet needs

2.1 Being "othered" by adults responsible for youths' care (3, 8 mentions)

A subjective assessment shared among focus group participants was their being aware of how they were being treated differently from other children in the household, with a pronounced hierarchy of status and privilege. Sometimes it was associated with gender, sometimes with race/ethnicity, sometimes with longevity in the household and/or foster vs. blood family status. Whatever the difference, participants noted experiencing being "the other" in ways that mattered. Many felt intentionally "singled out" and alienated. While participants did not verbally link these difficulties with PTSD, these experiences of difference were presented as enduring wounds they carry with them as young adults. As one respondent noted, "You had the aspect of like, we were sitting there eating Ramen noodles and hot dogs all the time. Then the [biological] kids were eating these like, expensive meals." For this respondent, these food differences at the same meal were among the ways that differential treatment occurred. For another, a gendered hierarchy, rigidly imposed, shaped her childhood in foster care:

Yeah, there was some homes that like I went into and there was uh one in particular that I swear they were sexist. They let the boys go outside and play. But I had to come home. I was always behind on my chores. Always behind. Never finishing. So, I had to clean, and, you know, eat and then sleep. That was it. That was…

Respondent 2 – Quote unquote, becoming the woman of the house. That sounds to me like what they were pushing.

First respondent – I just didn't think it was very fair.

Facilitator – In what circumstance did the boys have chores?

First respondent – They were outside playing! They were also— That family was, I don't know. I would say. I don't know. They were very, I think, like, old fashioned. We had to

go to church and when we went to church, like she made me wear a dress and the dress was like [way outdated].

This moment of dialogue between respondents demonstrates some of the best inter-group engagement the focus group method creates, opportunities for dialogue, helping refine and clarify the concept under discussion.

In addition to gender-informed "othering," another respondent noted the alienation and different treatment they experienced based on race:

I don't think they noticed that they did it, but they definitely treated us differently because we're not White. Even now, like [another participant name] has to live there and he knows all about this. He likes to go on night walks, he likes his isolation.

Some respondents attributed the experience of being othered and stigmatized as being a product of a systemic hierarchy practiced within the foster care system. As one respondent put it:

I also feel like the caseworkers and the whole children services, they have like, they're favorite cases, too. I don't want to say favorite, but I feel like they seem like they think some cases are more important than others. I've been on both sides. I feel like everyone's case should be taken seriously, and not one. Because one person's case, you might not say, is as serious. Oh, they're doing fine in the residential, but it's actually more serious than that. They're not doing fine. But you know, check on them.

Another respondent made a similar point, focusing on their experiences at a residential youth facility:

With the floor staff, because I also went to the [residential youth facility]. For them, I feel like a lot of them favored different people. So, they would give different people certain things that they wouldn't [give others]. Then they would count you out of it. So, it was like, you would see other persons get more stuff. Or rewarded. Or get to go out more than you would… So, it was like, unfair, in my opinion.

2.2 Being powerless regarding healthcare (6, 6 mentions)

Similar to Theme 1.3 above, being unable to participate in their own health care is another form of differential treatment respondents discussed. They expressed this as another circumstance of the denial of their own agency. This is consistent with recent research of the U.S. foster care system, which found "widespread overuse of psychotropic medications with vulnerable children in foster care settings" (Drake 2019:358). Echoing Drake's findings, several respondents reflected his sentiment that, "These vulnerable children need comprehensive care

to address the social determinants of poor health as well as comprehensive treatments" (2019:358). For participants, this included a feeling of being overprescribed medications, which then became yet another burden and imposition. As one respondent said:

> *I feel that – I honestly feel a lot of resentment, because I feel in addition to the trauma of being taken out of my home, and feeling that it was my responsibility to, like, reunite myself back with my family, and like not be a bad person anymore, that like permanent damage has been done to my brain because of the medications that they were giving [me]. And I'm not the only kid [this happened to]. …But my mom was even trying to advocate for me, and saying she's not, not been on an antidepressant since she was 12 years old. "Maybe we shouldn't have her on any meds, so we can just establish what a baseline is, now that like she's in this safe environment." And they're like, "No." And [they] had me on just, multiple medications the entire time I was there. They would start and stop multiple medications at once. So, at that point, I'm like, 'You don't even know what's doing what!*

> *I don't understand why our healthcare system jumps straight to medication-… Instead of therapy and actually trying to dig into your problems before throwing you on medication.*

2.3 Feeling exploited for income (7, 11 mentions)

Another theme that emerged was respondents' concern about what they experienced as financial or other ulterior motives of foster parents. While the words "altruism" and "sincerity" were not used, participants seemed to wish they had experienced or perceived those principles in their foster parents. While motives for foster parenting are many, research suggests that "the most frequently endorsed reasons for fostering reflected foster parents' altruistic and internal motivations to foster, [extending from] their perceptions about teamwork, communication, and confidence in relation to both the child welfare agency and its professionals" (Rodger et al. 2006:1129; see also Davi et al. 2021). However, among our respondents, reference was made to motives that were material rather than being of service, or being informed by faith or other similar intentions, as is reflected in prior research. In addition to spending money from the state on clothes and preparing the foster children for a new school year—as was intended for the funding—multiple respondents suggested that money was instead pocketed and used for personal gain by the adults, and that the children never benefitted from it. This included budgeting exploitatively:

> *I got like social security benefits until I turned 18 because both of my parents passed away. So, I had survivor benefits. I knew exactly how much it was because I just found papers one day and it was like $712 a month. They gave me none of it. And I was like "Where is it going?" And they basically just explained that "We're paying the whole rent*

with it." And I was like, "I need school clothes, and everything else, and like, hygienic products and stuff like that!"

Once COVID hit and we were home from school, it just got progressively worse. It got to the point where she basically quit her job and she was at home for almost the entirety of COVID just living off the money she would get from the four of us. We lived on the south side of (the city)… We were responsible for all the chores in the house. Basically, everything to make the house still function. Meanwhile, she stayed in her room and played on her Xbox that she bought with the money from us. [Sigh]. So that was very frustrating.

Our lives are not for profit.

One respondent linked financial concerns with the over-medication, "*because the more medical paperwork they have on a kid, the more likely they'll get more money off of them."* As noted in prior research, "Several respondents expressed their belief that they were due stipends or clothing allowances that they did not receive; that is, the child welfare agency or other government programs did not provide the money, or their group homes or foster parents did not pass the funds along" (Peters et al. 2016:7). This sentiment was shared by multiple of our respondents and is consistent with this research. Those who felt their foster family circumstance was not motivated by money were the exception in our groups, even as they simultaneously supported the findings of Peters and her colleagues. One respondent called attention to the foster family he was raised in, which was not motivated by money. He stated:

It's like, wow. Okay. They also never did it for the money [the family he was fostered in]. They had it. But yeah, that's an outlier of foster parents, I've learned, talking to multiple foster youth, and everything [to have been foster parented by a family that was not motivated by money]. Which, I've noticed, that's a big, major problem in foster care. They're doing it purely for the paycheck they get from the [foster] children.

Theme 2.4 Experiencing stress and trauma without support (0, 8 mentions)

Another substantial theme that was expressed among respondents was post-traumatic stress. Established in prior research, "Youth in foster care are more likely than non-foster care youth to experience post-traumatic stress disorder (PTSD) [and] several forms of emotional abuse had the most centrality as compared to other forms of trauma and were significantly associated with PTSD symptoms [and] may be particularly important in the development of PTSD" (McGuire et al. 2021:2, 12). Assessing threshold indicators for PTSD was not the intent of the focus groups, and data to do so were not collected. Still, the adverse aftermath of traumatic experiences while in foster care seemed apparent among several respondents. As one

participant noted, as he began crying while recounting his experiences (which led us to pause the focus group):

> *It ended up being where her son had abused, uh, my younger sister. And there was like. All they pretty much said was [voice cracks], "Uh, sorry." They just like, took him out the house and that's it. There was no repercussions. Like, why was this going on? Why was these things happening? And even like. There's like. It didn't feel like there was anybody that I was able to like, talk to. There should have been like some sort of [resource available]. Even if I was in kindergarten, first, or second grade. There should be a counselor, like regular counseling sessions.*

At times, experiences of trauma were familial. At other times, participants reported more indirect experiences of alienation and both micro- and macro-aggressions that were traumatizing. These experiences were made worse and more damaging as a result of the lack of willingness to believe the incidents by those they sought out for support.

Category 3. Best practices for adult assigned to represent youth

Respondents were asked to recommend "best practices" for adults assigned to support and care for children while in the child welfare system.

3.1 Provide emotional support to address past trauma (24, 5 mentions)

Emotional support was the most frequently mentioned best practice that respondents across the focus groups identified as critical for youth going through the child welfare system. In 2021, Ohio had more than 15,000 children in out-of-home care as a result of abuse, neglect, or dependency and more than 24,000 children who were the subject of a substantiated report of abuse or neglect. Ohio also had more than 100,000 children who were the subject of an investigated report of child maltreatment (Ohio HHS 2021; https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/ohio.html).

Recent research supports the value of understanding the lifelong effects of developmental adversities and "has clarified the need for an organized strategy to identify and intervene with children, adolescents, and families who may be at risk for maladaptive responses. Trauma-informed care (TIC) in child health care operationalizes [evidence and] insights of attachment and resilience to enhance health care delivery to mitigate the effects of trauma" (Duffy et al. 2021:1). Although our focus group participants recognized that attorney GALs and CASA volunteers are not qualified to provide therapy, they suggested that youth would benefit from adults being more knowledgeable about the impact of family separation and past trauma and from building supportive relationships that could reduce the impact of these stressors.

Understanding what the signs of trauma look like and how to break through with people there, instead of just not being aware of these things that make a really big impact. … I was a cutter for a little bit and whatnot and it's like I'm not doing this because everything is great. Punishing me for this is not helpful.

Some basic questions, like just have some standard questions to start the conversation, like how's your needs? … Emotionally where you at? Are you getting along with your parents right now? What's going on with them?

Therapeutic trust is a developmental process for all persons and may be especially challenging for those who have experienced severe trauma. The process of healing, if not sensitive to past trauma, may contribute to exacerbating the experience of trauma. When resourced and delivered well, though, the healing of trauma-informed care can succeed.

When I was in care, I had seen a therapist a few times. But the thing is, is the way that they did it, traumatized me. Like it didn't- it wasn't good. So, when I was growing up and I was having these kind of like behavioral issues, I didn't trust them. I wasn't going to tell them. Like no one's ever listened to me before, why would I tell you now. And, like, as I've gotten older, I've learned to trust therapists more or less.

As one respondent reflected on the challenges they experienced while in foster care, "I had a counselor [while in foster care]. But there is only so much a counselor can do when the trauma is ongoing." Despite the melancholy reflected here, even this survivor of prior systemic trauma acknowledged the value and importance of access to, and information and support shared by, adults who were assigned to care for them.

Having some continuity in supportive relationships was also identified as a high priority. Respondents described how helpful it was to have the same individuals supporting them over time, while others described the negative impact of moving from home to home for no apparent reason and having to reestablish relationships at each turn.

Around 10, no, 11, I got, I got a counselor that kinda stuck with me, through most of the time.

Being in… circumstance where kids are just going from one family to another family, to another family, because something they didn't like, or something the family didn't like, something small. So, I don't know, for me, like, I think that there should be like a relationship coach, or a family coach, where they can really just sit down, and this should be mandatory for everyone.

Okay. If you move, you know, I know even non-foster kids, they move a lot. It's just hard to build any relationships.

3.2 Build skills for independent living (11, 7 mentions)

Among the best practices that participants identified repeatedly were opportunities to develop skills they needed to live and function on their own. The skills mentioned most frequently included meal preparation and the ability to drive. Several respondents suggested that the opportunity to obtain a driver's license should be mandatory prior to emancipation. Others described the need for guidance regarding their future – having a plan for going to school or working – as important minimum requirements for emancipation. A third area of preparation related to relationships; respondents described the need for guidance to establish healthy relationships and avoid potential exploitative relationships.

You should know how to cook before you leave. You should have a clear path.

I think maybe just having someone after you age out just follow up with you, where you at? You know?

It's like an apartment, they help you build credit and stuff like that, get everything together, finish school if you didn't finish school.

Driving, I think, really needs to be a thing. Allowing youth to obtain a driver's license while they're in care. And just like college prep stuff, like help with college prep. Because I had no help with that.

Independent Living is so varying depending on where you are, and I think that should not be the case. I think that it should be, you know, I understand that Ohio is a state-run, county-administered place, but I think that the state needs to do a better job of mandating minimums when it comes to [preparation for] Independent Living.

3.3 Value the youths' perspectives; support self-determination by providing a voice (9, 10 mentions)

Respondents described the need to place greater value on the perspectives of children in their care as a critical best practice. Youth in foster care possess unique insights and experiences that can provide valuable input into decisions about their care, education, relationships, and future planning. Including their perspectives in these discussions leads to more informed and effective decision-making, ensuring that their individual needs and preferences are considered. By providing youth with a voice, adults acknowledge youths' inherent worth and promote a sense

of self-determination that supports their overall well-being. In many cases, youth described how adults dismissed their perspective.

> *When he was younger they weren't listening to him and he knew what was going on and I feel like there really needs to be an emphasis on respecting and valuing the child's voice. I feel like that gets lost in a lot of ways and spaces. I've heard even people say, "They're not age appropriate," or, "They're a kid, they don't know."*
>
> *I think that you should always, if you can't include the child's voice in the moment, you should include former foster youth as trainers for CASA volunteers. I think you should always incorporate their voice as much as you can.*
>
> *I think the biggest thing would be a lack of dignity. I would say people need dignity training, I think. Learn how to treat people with dignity.*

The Youth Ombudsman's office was identified by several respondents as a potentially valuable resource for youth to have their voices heard.

> *I was just going to say, I think overall, we've heard, overall, that the Youth Ombudsman's office just has been needed for a long time, and hopefully that office will be a place that actually listens and hears what children have to say. It would be nice if all children could be assigned an advocate.*
>
> *I was a teen mom and I'm telling them, like, this is what my son needs, but because I was a child, … they didn't see me as a whole person. They were just like, okay, well, you know, you gotta understand. And it's like, I don't have to understand. You took me out of my home and this is worse than where I was. You could have left me there. And there's no one, you know, again apparently, I want accountability, because I keep saying that. But there was no one that I could call if I didn't- and I know now we have the Ombudsman- but I feel like, if there's still people that don't know about that, but I don't think that that erases the other side- that we should be adhering to what's in place, um, to try be a catch-all for kids*

3.4 Invest in relationships between youth and adult advocates (12, 7 mentions)

Focus group participants repeatedly expressed the need for adult advocates to spend sufficient time to build a relationship, understand individual needs, assure that decisions about youths' care are well-informed, and protect them from future adverse experiences.

Regarding the Guardian ad Litem, there was just one more thing I wanted to say. If there's any training, other than— Actually, just please spend time with people. Because I cannot, for the life of me, remember this guy's name, or face. I know I talked to him, but I feel that I was always fighting to talk to my caseworker, or GAL.

The lack of one-on-one meetings, or not being able to meet with them as often, because I only met with mine like once or twice. When I was with her, I guess, it was like short meetings, we never really talked about much. It was just about moving placements and stuff like that.

I needed somebody to be able to like, tell me what was going on….At the beginning it was framed like I was the one who was unfit for the family. At that point in time, in my head, it felt more like an incarceration situation, which was just very confusing for me to wrap my head around.

As a former foster youth who is now a social worker noted:

There needs to be a mandatory amount of time you meet with the child. I know I probably had a Guardian Ad Litem. But they never— I don't remember ever meeting them. If I did, it was so brief that I don't remember meeting them. If you are going to be the person representing a child's viewpoint in court, as a CASA or GAL, you need to have met with that child yourself, and have spent true time with them, getting to know them and hearing their voice. I hear that from foster youth all the time now. And like you said, opening up the group to different age groups. I aged out of care in 2005. It was an issue then, and it's still an issue now. I still hear the same, exact stories from former foster youth now. That nobody, their person, who was supposed to meet with them, did not meet with them. Or did not talk to them. Or there's this person in court who's making decisions or presenting information on their behalf, and they never got to know them. So that's first and foremost what you can do… You should include the child's voice in court, somehow.

3.5 Reinforce adults' accountability for youth outcomes (3, 15 mentions)

Respondents suggested a number of strategies to assure that adults who care for youth in the child welfare system are providing the support and oversight needed for youth to develop and thrive. Adult advocates and caretakers are in a position to make an enormous impact on children's lives by representing them appropriately in court proceedings, protecting them from harm, and providing them with support to deal with stressors and past trauma. Respondents felt that this responsibility must be fully understood and appreciated by any adults who pursues a child advocacy role.

I think that the GALs, because I didn't have a GAL, but I feel like when I saw them, I would watch them, you know, not be as involved, but they held a lot of weight. As a GAL and CASA. And they can mess up somebody's case. And I'm like, you have that level of power. You should be more involved in what's going on. You shouldn't be able to just show up and derail a case or plan for a youth and you've seen them maybe 30 minutes in 2 months. That's what I mean.

…[T]here are so many things that if we actually adhere to … could be a safety net for some of the stuff that we're hearing. … when I learned that every kid should have a psychological within 60 days, I feel like, you know, there are so many times when people go without medication because they haven't been assessed. Or they're on the wrong medication because they haven't been assessed. And I think that sometimes, the adults could have, for me, could have advocated for my needs.

They should have someone to like go in like every so often and do an inspection or something. I mean they do, but it's like, it's scheduled and expected and everything. I feel like it should be a different person like every time so that, you know like they're not prepared to clean anything up or cover anything up because that did happen a lot.

Adult responsibility included helping youth achieve better outcomes.

I feel like the people that are in youth's lives should be accountable for the outcomes. If they're supposed to be responsible for that youth achieving something, and they're not achieving it, why aren't they held accountable and not even like getting fired or something, but like, what happens when you don't refer for Independent Living?

3.6 Support for cultural differences and preferences (7, 9 mentions)

Respondents described the importance of having adults understand and appreciate cultural differences in order to provide a nurturing and supporting environment that is responsive to each child's individual needs. Youth described best practices that could help them preserve their cultural identity and feel a sense of belonging.

I knew how to cook going into foster care and I would often be like, "Hey, can I cook dinner?" "No, it's a privilege." But giving the child a little bit of opportunity to share that culture if, just to keep you informed, like, "Hey, this is who I am, learn a little bit about it." Even that, just keeping an open mind as a foster parent would be beneficial for the child's development in the future.

Even something as simple as hair care. It's very different when you're a person of color. Your hair is very, very different from a White person's hair. And I just think even that is something that isn't looked at and needs to be looked at.

> *I think there definitely needs to be a screening in place to look at the differences that could hurt a child or make them feel isolated. Because they're already in a very isolating situation.*

Though relatively limited in the focus groups, the emotionally charged theme of cultural competence was raised. Lack of cultural understanding was expressed in several ways: disrespect, passive ignorance, or a more apparently malicious imposition on the foster child, and perhaps on others as well. Consistent with this theme, respondents recounted ways in which sensitivity to children's cultural backgrounds could be incorporated into training.

> *Like we are both very much aware that we are, like we can be perceived as suspicious if we walk around at night. It's not that, it's the ignorance in the way that she says it. Like being able to understand how maybe the way you might phrase something can come across as ingenuine and not caring, it's not-I'm very happy that she recognizes that we are in danger and being brown puts a target on your back in this country. Like, yes, that's great that you recognize that, but it's the way that she said it is not- it wasn't okay, like just the approach wasn't kind.*

> *… [K]nowledge about the kind of differences you might encounter. And how a child might not be acting out and not wanting to eat something they don't understand. Like the new food, or it's too different. Like having someone who can explain like these different kind of things.*

As another stated, more explicitly:

> *Then other aspects of the cultural— Like, for me, it's like I am a weird set of minorities. My ancestors, my African ancestors, didn't get here through the slave trade. They got here through immigration. My father was from Ethiopia. So, it's like I connect more with Ethiopian culture than African American culture. So, it's like, I feel like even if you don't have a place that you can put a child [with] a foster family that has that same background, you should still make sure that those foster parents have some understanding of that cultural background, so that they. Or, at least like take them to a cultural fair. Or have them talk to the community that has that background, so that child doesn't lose who they are.*

For those operating in the child welfare system, "When placed in out-of-home care, a youth's cultural identity should be promoted and nurtured" (Lee et al. 2015:508). Participants expressed a strong desire for expressions of informed empathy and related practices that support their well-being.

Discussion

This report focuses on perspectives of individuals with unique expertise in the needs of youth in the foster care system. Participants provided first-hand accounts of their experiences, the types of support needed from caretakers, and the impact of not having the support that they needed. They described needing greater personal safety and more protection from abuse; they cited the need for adults to believe and act on their reports of abuse, stress, and trauma. Participants reported the lack of help gaining basic necessities, such as clothing, educational services, transportation, and financial resources. Many discussed experiences of bias based on race, gender, and culture, as well as alienation within foster homes.

Focus group participants reported wishing they had been given a much stronger voice in several matters that directly impacted their lives: from court proceedings and decisions about their placements to the treatment of health conditions, including mental health. Some felt exploited for income from the foster care system, and some expressed the need for greater skill-building as they approached transitioning out of foster care.

These and other key findings from the focus groups lead to the following best practice recommendations and implications for CASA/GAL training:

- *Clarify financial rights and advocate for needed resources.*

Discussed above in Theme 2.3 regarding motives for foster parenting, respondents desired greater clarity and transparency regarding their financial rights. Training for ethical fiscal practices would likely be targeted at how CASA volunteers and attorney GALs communicate about finances with involved adults, perhaps in association with relevant regulations confirming the amount, time, and distribution of funds in the best interests of the child. Training also could be provided to caretakers to help them gather information from CPS about financial support available to children and confirm that funds are being used in the way they are designated. Guidance would be helpful for older children and youth to increase their financial literacy and understand their rights related to financial support.

- *Provide training related to cultural humility.*

Participants in both focus groups identified cultural or racial biases or lack of competence contributing to a sense of isolation (e.g., see Theme 3.6). Respondents identified the need for more knowledge and respect for the diverse cultural backgrounds of the children in their care. The notion of cultural humility focuses on demonstrating a willingness to approach cultural interactions with openness while working to counteract stereotypes and biases. Unlike cultural competence, which focuses on building specific knowledge and skills to interact with diverse cultures, cultural humility is a mindset that promotes understanding and respect for different

beliefs, traditions, and practices; it helps children to maintain connection to their cultural heritage. By promoting cultural humility within the training, CASA volunteers and attorney GAL may build a sense of belonging and validation that is important to children's development.

- *Incorporate youth perspectives in decision-making about their placement.*

While other topics may have been repeated more frequently across the focus groups, perhaps the respondents' single most passionately affirmed subject was the need to ensure that training includes the need to integrate the child's voice in decision-making; this means appreciating, soliciting, and responding to the perspectives of the children in care. While volunteers may not agree with children's wishes regarding placement, they should be transparent with children about placement decisions, and include the child's perspective in reports to the court. As Walker and Misca (2019:375) have noted, "until recently, children and young people in many jurisdictions have rarely been given an opportunity to express their views about the decisions made on their behalf. As a result, they can become unhappy and marginalized and struggle to settle in new environments."

- *Investing in relationships with youth.*

A sentiment frequently heard during the focus groups was the need for adult advocates to spend sufficient time to build a relationship, understand individual needs, assure that decisions about youths' care are well informed, and protect them from future adverse experiences. The majority of respondents reported either being unsure if they ever had been assigned a CASA volunteer or attorney GAL, or if they had been assigned, spending very limited time with them in any capacity. Respondents were aware that the caseworkers, attorney GALs, and other adults assigned to look out for them were often overworked, distracted, and ill prepared to carry out this role. Yet effective advocacy can have substantial benefits on children's emotional health and welfare. If done poorly, however, the impact can be highly detrimental to children. The stories shared by focus group participants suggest that the role could be greatly improved if advocates were able to spend more time with children in their care and develop meaningful relationships. Many children in the child welfare system have experienced trauma, abuse, or neglect, which may make it challenging to trust adults. Advocates who are more consistently present, engaged, and supportive can help children build a foundation for healthy relationships in the future. Trainings should repeatedly reinforce that regular respectful, child-centered, and when necessary, trauma-informed interactions are ~~also~~ crucial to enable advocates to monitor progress and respond to new challenges that could interfere with children's progress.

- *Foster shared decision-making for health care.*

A significant body of research indicates that shared decision-making results in more personalized and effective care (Opel, 2018). Within the child welfare system, shared decision-

making can empower youth by involving them in the decision-making process regarding their health care. Even if a health care decision cannot fully address a child's wishes, shared decision-making includes discussing the benefits and risks of various treatment options. As described in Themes 1.3 and 2.2, youth described a sense of powerlessness regarding their healthcare. Foster youth often have unique healthcare needs resulting from a variety of factors such as prior trauma, disrupted family backgrounds, or ongoing instability. Training should role play and model how shared decision-making allows health care professionals and caretakers to consider the specific circumstances and preferences of each child and ensure that their perspectives are considered.

- *Incorporate role-appropriate training for trauma-informed care.*

CASA volunteer and attorney GAL training must not try to provide holistic, therapeutic training. Still, training from within the role can nurture healing. Trauma-informed care is generally understood as a comprehensive, multilevel approach that shifts how organizations and people explore and respond to trauma. As Oral et al. (2016:231) suggest, "Transforming organizations into trauma-informed systems entails organizational changes and the development of culturally sensitive infrastructure that is responsive to the needs of traumatized individuals." Extending from the emergent narratives of our focus groups respondents, future trainings for CASA volunteers and attorney GALs in Ohio could benefit from awareness of, and formative strategies for, trauma-informed care within the parameters of the volunteer role; the result would enable CASA volunteers and attorney GALs to more effectively realize the mission of their work.

Conclusion

The focus groups with members and affiliates of the CSSN provided a personal, nuanced view of the experience of being in the foster care system. Their accounts provide a helpful perspective to identify best practices and training priorities of present and future CASA volunteer and attorney GAL programs. This type of input can help to improve the care provided by adults who are responsible for their care.

References

Arredondo, David E. 2003. “Child Development, Children’s Mental Health and the Juvenile Justice System: Principles for Effective Decision-Making.” *Stanford Law & Policy Review* 14:13-28.

Davi, Nicole, Jennifer Jones, and Martie Gillen. (2021). "An exploration of the motivations and barriers to being a foster parent in Florida." *Children and Youth Services Review* 131: 106261.

Drake, Robert E. (2019). Overmedicating vulnerable children in the U.S. Epidemiology and *Psychiatric Sciences* 28, 358–359. https://doi.org/10.1017/ S2045796018000689

Fry, Vanessa, Jacqueline Lee, Cheong Kim, and De’Andre Matthews. (2022). Idaho Guardian ad litem 2022: Program Evaluation. Idaho Policy Institute, Boise State University.

Lee, Terry, George Fouras, and Rachel Brown. (2015). "AACAP OFFICIAL ACTION." *Journal of the American Academy of Child and Adolescent Psychiatry* 54: 502-517.

McGuire, Austen, Lindsay Huffhines, and Yo Jackson. (2021). The trajectory of PTSD among youth in foster care: A survival analysis examining maltreatment experiences prior to entry into care. Child Abuse Negl. 115:105026. doi: 10.1016/j.chiabu.2021.105026.

Opel, Douglas J. (2018). A 4-step framework for shared decision-making in pediatrics. *PEDIATRICS* Volume 142, number s3, November 2018: e20180516E

Oral, Resmiye, Marizen Ramirez, Carol Coohey, Stephanie Nakada, Amy Walz, Angela Kuntz, Jenna Benoit, and Corinne Peek-Asa. (2016). Adverse childhood experiences and trauma informed care: the future of health care. *Pediatric Research* 79:227–233. doi.org/10.1038/pr.2015.197

Peters, Clark M., Margaret Sherraden, and Ann Marie Kuchinski. (2016). “From foster care to adulthood: The role of income.” *Journal of Public Child Welfare* 10:39-58. doi:10.1080/15548732.2015.1090940

Rodger, Susan, Anne Cummings, and Alan W. Leschied. (2006). Who is caring for our most vulnerable children?: The motivation to foster in child welfare. *Child Abuse & Neglect* 30:1129-1142. https://doi.org/10.1016/j.chiabu.2006.04.005.

Walker, Janet, and Gabriela Misca. (2019). Why Listening to Children and Young People is Important in Family Justice. *Family Court Review* 57:375-386.

Appendix A. Record Linkage Procedure

This project required us to link three administrative datasets at the individual level: SACWIS Data, Medicaid enrollment and claims data, and CASA program management data (CASA Manager data system).

The approach for each linkage was determined by the available identifiers in each set. The three datasets do not all contain a common unique identifier, such as Social Security Number (SSN), meaning that a simple one-to-one linkage across all three datasets is not possible. Instead, we used a combination of two linkage methods to identify individual records in each data source.

Deterministic linkage assesses identifiers in two or more datasets for an exact match. It is useful when data sources contain identifiers that are generally reliable for identifying unique individuals such as SSN. This process was used to link SACWIS and Medicaid Enrollment records that contain SSN and date of birth, which together are highly effective at identifying unique individuals. Deterministic linkage was also used to link CASA and Medicaid Enrollment records that contain first name, last name, and date of birth, which are also highly effective at identifying unique individuals.

Probabilistic linkage assesses combinations of common identifiers to identify records in different datasets that are likely to refer to the same individual. For example, different individuals may share the same first or last name or date of birth, but two records with the same first name, last name, and date of birth are likely to match the same individual. Linkplus is a linkage software program that produces a score based on the similarity of common user-specified fields. Manual review of scored potential matches was then conducted to assign cut-off points and rules for true matches while weeding out evident false positive matches.

Probabilistic linkage is also useful when working with administrative records that may contain data entry errors or missing fields. For example, the birthdate “01/01/1998” shares a certain resemblance with “01/01/2998,” and it is likely that the latter is an input error. If all other identifiers matched except for date of birth, the manual review process allows the user to attribute both records to the same individual. For names, the similarity criteria are more complex because names may differ across datasets for legitimate reasons such as the use of nicknames, suffixes and prefixes, and misspellings. For this project, name and address changes may occur more frequently because of custody changes and adoption. Probabilistic linkage

methods allow records with a few differences to be linked if other common identifiers are similar.

We used probabilistic linkage based on first name, last name, date of birth, sex, county, and address(es) to link CASA program records with Medicaid enrollment data and SACWIS data for records that did not match exactly on first name, last name, and date of birth. We also used probabilistic linkage to link Medicaid enrollment records to SACWIS records that did not match using the deterministic linkage process due to missing or incorrect SSN or date or birth. While changes in address and last names make linkage challenging, CASA program data include parents' names and addresses, which were used during the manual review process to identify additional matches.

Deterministic linkage is efficient, requiring very little time to categorize pairs with matching criteria as "true matches." However, data errors in SSN and date of birth do occur and introduce the possibility of attributing false positive matches during the deterministic linkage step. For this reason, we included a quality assurance steps after each deterministic linkage to review and remove individuals who falsely matched. We evaluated false positives by calculating a generalized edit distance score and examining pairs for which name and/or date of birth are very dissimilar.

Finally, the availability of SSN, name, and date of birth on both SACWIS and Medicaid Enrollment records provide a strong and complete set of identifiers for linkage. We therefore accept the linkage between SACWIS and Medicaid to be very accurate, allowing us to bolster the linkage between CASA and Medicaid and between CASA and SACWIS. A final linked set was a crosswalk between all three datasets, components of which were used to create the analytic sample, covariates, and outcome measures.

Appendix B. Additional Tables for Quantitative Analysis

Table B1: Regression Estimates for Rural County Analyses

	Placement Changes	OOHP	Re-entry	Reunification	Permanency Placement	Restrictive Placement[a]	Timely WCV, Three Years or Less	Timely WCV, Greater than Three Years	Preventable ED Visits
(Intercept)	-0.076 (0.451)	-0.274 (0.003)	-	-0.590 (0.011)	2.248 (<0.001)	0.231 (0.524)	-4.624 (<0.001)	-5.978 (<0.001)	-6.056 (<0.001)
County Group									
Summit County	0.094 (0.201)	0.511 (<0.001)	0.218 (0.342)	-0.153 (0.367)	-0.617 (0.033)	-0.722 (0.007)	-0.127 (0.047)	-0.101 (0.146)	-0.172 (0.004)
Seneca County	0.233 (0.018)	0.228 (0.016)	0.572 (0.05)	-0.293 (0.234)	-0.949 (0.011)	-0.619 (0.144)	-0.089 (0.344)	-0.014 (0.887)	0.249 (0.002)
Clinton County	0.000 (0.999)	0.256 (0.023)	-0.073 (0.851)	-0.182 (0.49)	-1.033 (0.008)	-0.739 (0.057)	-0.042 (0.736)	-0.076 (0.465)	-0.078 (0.423)
CASA	**-0.013 (0.891)**	**-0.197 (0.02)**	**0.112 (0.668)**	**-0.023 (0.916)**	**0.473 (0.154)**	**-0.552 (0.139)**	**0.051 (0.572)**	**0.158 (0.057)**	**0.288 (<0.001)**
People of Color (POC)[b]	0.136 (0.107)	0.015 (0.87)	-0.113 (0.696)	-0.098 (0.648)	0.787 (0.044)	0.084 (0.811)	-0.021 (0.772)	0.112 (0.231)	0.121 (0.107)
Female	0.054 (0.315)	-0.128 (0.014)	-0.227 (0.169)	0.108 (0.404)	0.336 (0.087)	0.492 (0.030)	0.007 (0.893)	0.012 (0.818)	0.236 (<0.001)
Prior Intakes									
One	-0.070 (0.290)	-0.043 (0.525)	0.280 (0.191)	0.266 (0.104)	-0.098 (0.695)	-0.406 (0.163)	-0.091 (0.091)	0.035 (0.624)	-0.025 (0.654)
More than One	-0.231 (0.002)	-0.109 (0.147)	-0.015 (0.950)	0.180 (0.329)	0.340 (0.229)	-0.676 (0.028)	-0.272 (0.013)	-0.058 (0.43)	-0.184 (0.003)
Prior OOHPs									
One	-	-0.437 (<0.001)	0.211 (0.548)	0.481 (0.116)	0.537 (0.295)	0.232 (0.643)	-	-	-0.049 (0.673)
More than One	-	0.294 (0.002)	-0.038 (0.887)	-0.546 (0.018)	-0.094 (0.759)	-0.006 (0.983)	-	-	-0.209 (0.006)
Any	0.097 (0.213)	-	-	-	-	-	-0.332 (0.057)	-0.055 (0.436)	-
Behavioral Health									
Child	0.321 (<0.001)	0.002 (0.969)	0.674 (<0.001)	0.607 (<0.001)	-0.999 (<0.001)	-	-0.492 (0.043)	0.051 (0.343)	0.263 (<0.001)
Parent	0.067 (0.223)	0.103 (0.051)	0.185 (0.283)	-0.171 (0.191)	0.157 (0.435)	-0.160 (0.500)	-0.017 (0.725)	0.004 (0.947)	-0.033 (0.464)
Geo. Isolation[c]									
Middle Third	0.056 (0.448)	0.074 (0.293)	0.189 (0.414)	-0.312 (0.078)	0.094 (0.722)	-0.826 (0.004)	-0.082 (0.219)	0.054 (0.459)	-0.117 (0.056)
Top Third	0.024 (0.775)	0.103 (0.195)	0.371 (0.176)	-0.482 (0.016)	0.019 (0.950)	-0.494 (0.142)	-0.092 (0.236)	0.033 (0.685)	-0.119 (0.094)
Child Opp. Index[d]	0.012 (0.736)	-0.046 (0.181)	-0.126 (0.220)	0.164 (0.057)	0.081 (0.533)	0.104 (0.466)	-0.011 (0.712)	0.020 (0.576)	-0.071 (0.011)
Tract Percent. POC[d]	0.007 (0.849)	-0.072 (0.057)	0.231 (0.022)	-0.053 (0.563)	-0.182 (0.151)	0.222 (0.179)	-0.031 (0.344)	0.019 (0.597)	0.022 (0.446)
CASA, POC Interaction[b]	**0.130 (0.374)**	**0.230 (0.121)**	**0.327 (0.456)**	**-0.038 (0.922)**	**-1.250 (0.030)**	**-0.268 (0.682)**	**-0.050 (0.702)**	**-0.186 (0.243)**	**0.294 (0.010)**

P-values for hypothesis tests of coefficients being different from zero are shown in parentheses.
[a]Model only considers children with a behavioral health diagnosis; [b]Indicator of non-White race/ethnicity
[c]Observations were categorized by whether they fell in the bottom, middle, or top third of this index in the sample
[d]Standardized to have a mean of zero and a standard deviation of one

Table B2: Estimates of the Effect of CASA Appointment by Race/Ethnicity for the Rural County Analyses

	White	People of Color	Estimate of the Multiplicative Effect on the:
Placement Changes	0.987 (0.824, 1.183)	1.125 (0.874, 1.447)	Placement changes per OOHP
OOHP	0.821 (0.695, 0.970)	1.033 (0.798, 1.338)	Proportion of observation period spent in OOHP
Re-entry	1.118 (0.670, 1.866)	1.551 (0.714, 3.370)	Instantaneous risk of re-entry
Reunification	0.977 (0.642, 1.489)	0.941 (0.473, 1.875)	Odds of reunification
Permanency Placement	1.604 (0.838, 3.072)	0.460 (0.167, 1.267)	Odds of a permanency placement
Restrictive Placement[a]	0.576 (0.277, 1.196)	0.440 (0.132, 1.474)	Proportion of placement time spent in a restrictive placement
Timely Well-Child Visits			
Three Years or Less	1.052 (0.881, 1.257)	1.001 (0.800, 1.253)	Rate of timely WCVs
Greater than Three Years	1.171 (0.995, 1.379)	0.972 (0.729, 1.297)	Rate of timely WCVs
Preventable ED Visits	1.334 (1.161, 1.533)	1.789 (1.467, 2.183)	Rate of preventable ED visits

Intervals are 95% confidence intervals

[a]Model only considers children with a behavioral health diagnosis

Table B3: Predicted Outcomes for the Average Child in a Race/CASA Group for Rural County Analyses

	People of Color No CASA Appointment	People of Color CASA Appointment	White No CASA Appointment	White CASA Appointment
Number of Placement Changes	1.12 (1.044, 1.2)	1.283 (1.103, 1.492)	1.106 (0.938, 1.303)	1.443 (1.163, 1.79)
Probability of Being in an OOHP	0.481 (0.452, 0.51)	0.432 (0.392, 0.473)	0.485 (0.438, 0.531)	0.493 (0.437, 0.548)
Probability of having Re-entered by One Year	0.089 (0.067, 0.109)	0.08 (0.038, 0.119)	0.099 (0.054, 0.141)	0.121 (0.047, 0.189)
Probability of Reunification	0.324 (0.288, 0.361)	0.302 (0.227, 0.39)	0.319 (0.243, 0.406)	0.29 (0.183, 0.427)
Probability of Permanency Placement	0.853 (0.819, 0.882)	0.927 (0.86, 0.964)	0.903 (0.836, 0.945)	0.855 (0.728, 0.928)
Probability of Being in a Restrictive Placement[a]	0.298 (0.215, 0.398)	0.197 (0.102, 0.344)	0.316 (0.179, 0.494)	0.169 (0.063, 0.38)
Timely Well-Child Visits per Year				
Three Years or Less	2.753 (2.572, 2.946)	2.697 (2.385, 3.049)	2.897 (2.472, 3.396)	2.699 (2.218, 3.286)
Greater than Three Years	0.899 (0.841, 0.96)	1.005 (0.846, 1.193)	1.053 (0.91, 1.217)	0.977 (0.763, 1.25)
Number of Preventable ED Visits per Year	0.797 (0.751, 0.847)	0.9 (0.786, 1.031)	1.064 (0.941, 1.203)	1.611 (1.373, 1.89)

Intervals are 95% confidence intervals

[a]Model only considers children with a behavioral health diagnosis

Table B4: Regression Estimates for Metropolitan County Analyses

	Placement Changes	OOHP	Re-entry	Reunification	Permanency Placement	Restrictive Placement[a]	Timely WCV, Three Years or Less	Timely WCV, Greater than Three Years	Preventable ED Visits
(Intercept)	-0.434 (<0.001)	0.045 (0.479)	-	-0.279 (0.065)	1.971 (<0.001)	-1.484 (<0.001)	-4.938 (<0.001)	-6.234 (<0.001)	-5.953 (<0.001)
CASA	**0.367 (<0.001)**	**-0.050 (0.539)**	**-0.173 (0.538)**	**-1.179 (<0.001)**	**-0.083 (0.815)**	**-0.581 (0.192)**	**0.109 (0.285)**	**0.270 (0.005)**	**-0.200 (0.014)**
People of Color (POC)[b]	0.142 (0.028)	-0.078 (0.133)	0.088 (0.533)	0.156 (0.193)	-0.044 (0.823)	0.241 (0.326)	-0.092 (0.086)	0.025 (0.680)	-0.004 (0.918)
Female	0.077 (0.094)	-0.020 (0.601)	-0.092 (0.382)	0.182 (0.052)	0.082 (0.585)	-0.022 (0.903)	-0.010 (0.820)	0.024 (0.590)	0.110 (0.001)
Prior Intakes									
One	-0.081 (0.164)	-0.105 (0.024)	0.036 (0.797)	0.038 (0.737)	0.029 (0.883)	-0.035 (0.889)	-0.113 (0.013)	0.001 (0.981)	-0.161 (<0.001)
More than One	0.050 (0.395)	-0.115 (0.025)	0.225 (0.106)	0.029 (0.812)	-0.344 (0.077)	-0.079 (0.718)	-0.423 (<0.001)	-0.022 (0.706)	-0.186 (<0.001)
Prior OOHPs									
One	-	-0.220 (0.003)	-	0.225 (0.305)	0.731 (0.094)	0.326 (0.417)	-0.915 (<0.001)	-0.112 (0.292)	-0.666 (<0.001)
More than One	-	0.176 (0.006)	-	-0.244 (0.124)	-0.514 (0.014)	0.374 (0.081)	-0.193 (0.138)	0.018 (0.788)	0.019 (0.729)
Any	0.224 (<0.001)	-	0.250 (0.069)	-	-	-	-	-	-
Behavioral Health									
Child	0.271 (<0.001)	-0.048 (0.256)	0.308 (0.007)	0.418 (<0.001)	-0.525 (0.001)	-	-0.179 (0.094)	-0.021 (0.65)	0.285 (<0.001)
Parent	-0.101 (0.031)	0.102 (0.009)	-0.013 (0.908)	-0.174 (0.067)	0.279 (0.068)	-0.408 (0.028)	-0.003 (0.949)	0.038 (0.408)	0.028 (0.408)
Geo. Isolation[c]									
Middle Third	0.131 (0.023)	0.022 (0.643)	-0.219 (0.09)	-0.095 (0.418)	0.342 (0.065)	0.112 (0.613)	0.025 (0.635)	-0.047 (0.398)	0.088 (0.034)
Top Third	0.095 (0.139)	0.048 (0.362)	-0.232 (0.112)	-0.108 (0.398)	0.312 (0.129)	0.119 (0.637)	-0.052 (0.379)	-0.112 (0.074)	-0.006 (0.902)
Child Opp. Index[d]	-0.053 (0.046)	-0.051 (0.031)	-0.080 (0.213)	-0.010 (0.860)	0.019 (0.836)	0.127 (0.293)	0.040 (0.114)	0.033 (0.217)	0.002 (0.934)
CASA, POC Interaction[b]	**0.124 (0.335)**	**0.273 (0.019)**	**0.505 (0.153)**	**1.137 (<0.001)**	**-0.610 (0.169)**	**-0.775 (0.232)**	**-0.080 (0.571)**	**0.044 (0.721)**	**-0.352 (0.003)**

P-values for hypothesis tests of coefficients being different from zero are shown in parentheses.
[a]Model only considers children with a behavioral health diagnosis; [b]Indicator of non-White race/ethnicity
[c]Observations were categorized by whether they fell in the bottom, middle, or top third of this index in the sample
[d]Standardized to have a mean of zero and a standard deviation of one

Table B5: Estimates of the Effect of CASA Appointment by Race/Ethnicity for the Metropolitan County Analyses

	White	People of Color	Estimate of the Multiplicative Effect on the:
Placement Changes	1.444 (1.181, 1.766)	1.635 (1.400, 1.909)	Placement changes per OOHP
OOHP	0.951 (0.811, 1.116)	1.250 (1.061, 1.473)	Proportion of observation period spent in OOHP
Re-entry	0.841 (0.484, 1.46)	1.393 (0.908, 2.135)	Instantaneous risk of re-entry
Reunification	0.308 (0.184, 0.515)	0.959 (0.655, 1.405)	Odds of reunification
Permanency Placement	0.920 (0.458, 1.848)	0.500 (0.293, 0.852)	Odds of a permanency placement
Restrictive Placement[a]	0.560 (0.234, 1.338)	0.258 (0.101, 0.655)	Proportion of placement time spent in a restrictive placement
Timely Well-Child Visits			
Three Years of Age or Less	1.115 (0.913, 1.362)	1.030 (0.853, 1.243)	Rate of timely WCVs
Greater than Three Years	1.310 (1.086, 1.579)	1.369 (1.167, 1.605)	Rate of timely WCVs
Preventable ED Visits	0.819 (0.699, 0.96)	0.576 (0.486, 0.684)	Rate of preventable ED visits

Intervals are 95% confidence intervals

[a]Model only considers children with a behavioral health diagnosis

Table B6: Predicted Outcomes for the Average Child in a Race/CASA Group for Metropolitan County Analyses

	People of Color No CASA Appointment	People of Color CASA Appointment	White No CASA Appointment	White CASA Appointment
Number of Placement Changes	0.766 (0.686, 0.855)	0.882 (0.831, 0.937)	1.106 (0.93, 1.314)	1.442 (1.245, 1.671)
Probability of Being in an OOHP	0.499 (0.473, 0.525)	0.487 (0.451, 0.523)	0.48 (0.462, 0.497)	0.536 (0.495, 0.576)
Probability of having Re-entered by One Year	0.094 (0.071, 0.117)	0.102 (0.086, 0.118)	0.08 (0.04, 0.117)	0.139 (0.084, 0.191)
Probability of Reunification	0.447 (0.397, 0.497)	0.485 (0.456, 0.515)	0.199 (0.133, 0.287)	0.475 (0.384, 0.567)
Probability of Permanency Placement	0.89 (0.852, 0.919)	0.886 (0.864, 0.904)	0.882 (0.8, 0.933)	0.795 (0.7, 0.865)
Probability of Being in a Restrictive Placement[a]	0.194 (0.128, 0.284)	0.119 (0.056, 0.233)	0.235 (0.184, 0.294)	0.073 (0.03, 0.168)
Timely Well-Child Visits per Year				
Three Years or Less	2.236 (2.048, 2.441)	2.04 (1.926, 2.161)	2.493 (2.069, 3.006)	2.101 (1.747, 2.525)
Greater than Three Years	0.688 (0.62, 0.763)	0.705 (0.665, 0.748)	0.9 (0.768, 1.055)	0.965 (0.829, 1.123)
Number of Preventable ED Visits per Year	0.983 (0.914, 1.058)	0.979 (0.938, 1.022)	0.806 (0.697, 0.931)	0.564 (0.476, 0.668)

Intervals are 95% confidence intervals

[a]Model only considers children with a behavioral health diagnosis

Table B7: Regression Estimates for Within-County Analyses

	Placement Changes	OOHP	Re-entry	Reunification	Permanency Placement	Timely WCV, Three Years or Less	Timely WCV, Greater than Three Years	Preventable ED Visits
(Intercept)	0.364 (0.026)	0.595 (<0.001)	-	-2.449 (<0.001)	0.548 (0.323)	-4.837 (<0.001)	-5.803 (<0.001)	-5.736 (<0.001)
Butler County	0.349 (0.007)	0.200 (0.174)	-1.272 (0.006)	-0.556 (0.226)	0.756 (0.212)	-0.092 (0.517)	0.090 (0.516)	-0.240 (0.055)
CASA	**-0.082 (0.463)**	**-0.675 (<0.001)**	**-2.175 (<0.001)**	**1.354 (0.004)**	**2.305 (<0.001)**	**0.181 (0.109)**	**-0.187 (0.111)**	**-0.088 (0.354)**
People of Color[a]	0.132 (0.135)	0.041 (0.610)	-0.154 (0.523)	0.087 (0.72)	-0.192 (0.513)	-0.110 (0.113)	0.060 (0.526)	-0.111 (0.120)
Female	-0.212 (0.014)	-0.090 (0.252)	0.275 (0.253)	-0.110 (0.647)	-0.427 (0.150)	-4.837 (<0.001)	-5.803 (<0.001)	-5.736 (<0.001)
Prior Intakes								
One	-0.062 (0.557)	-0.078 (0.440)	-0.149 (0.67)	-0.528 (0.066)	-0.272 (0.492)	0.002 (0.976)	0.076 (0.568)	0.017 (0.837)
More than One	-0.148 (0.243)	-0.184 (0.131)	0.219 (0.566)	0.018 (0.956)	-0.660 (0.136)	-0.254 (0.104)	0.009 (0.948)	-0.399 (<0.001)
Prior OOHPs								
One	-	0.010 (0.966)	-	0.414 (0.507)	-0.791 (0.238)	-	-	-0.191 (0.383)
More than One	-	0.371 (0.010)	-	-0.246 (0.553)	0.972 (0.112)	-	-	0.164 (0.184)
Any	0.365 (0.003)	-	0.925 (0.008)	-	-	0.106 (0.504)	0.014 (0.915)	-
Behavioral Health								
Child	0.046 (0.644)	0.021 (0.826)	0.197 (0.461)	0.766 (0.006)	-0.313 (0.356)	-0.258 (0.253)	-0.182 (0.065)	0.027 (0.746)
Parent	0.020 (0.818)	0.126 (0.112)	-	0.118 (0.634)	-0.647 (0.041)	-0.023 (0.752)	0.005 (0.956)	-0.036 (0.618)
Geo. Isolation[b]								
Middle Third	-0.266 (0.012)	0.039 (0.704)	0.350 (0.234)	0.539 (0.062)	-0.347 (0.326)	-0.140 (0.084)	0.025 (0.821)	0.289 (0.001)
Top Third	-0.033 (0.795)	-0.107 (0.368)	-0.357 (0.412)	-0.071 (0.852)	0.388 (0.449)	-0.072 (0.501)	-0.012 (0.932)	0.271 (0.016)
Child Opp. Index[c]	-0.060 (0.284)	0.028 (0.555)	0.133 (0.414)	-0.043 (0.781)	-0.042 (0.833)	-0.019 (0.671)	-0.014 (0.812)	-0.148 (0.001)

P-values for hypothesis tests of coefficients being different from zero are shown in parentheses.

[a]Indicator of non-White race/ethnicity

[b]Observations were categorized by whether they fell in the bottom, middle, or top third of this index in the sample

[c]Standardized to have a mean of zero and a standard deviation of one

Table B8: Estimates of the Effect of CASA Appointment for Within-County Analyses

	Effect Estimate	Estimate of the Multiplicative Effect on the:
Placement Changes	0.921 (0.741, 1.152)	Placement changes per OOHP
OOHP	0.509 (0.401, 0.647)	Proportion of observation period spent in OOHP
Re-entry	0.114 (0.063, 0.205)	Instantaneous risk of re-entry
Reunification	3.871 (1.667, 10.628)	Odds of reunification
Permanency Placement	10.02 (4.874, 21.424)	Odds of a permanency placement
Timely Well-Child Visits		
Three Years or Less	1.199 (0.965, 1.504)	Rate of timely WCVs
Greater than Three Years	0.830 (0.661, 1.046)	Rate of timely WCVs
Preventable ED Visits	0.915 (0.761, 1.106)	Rate of preventable ED visits

Intervals are 95% confidence intervals.

Table B9: Predicted Outcomes for the Average Child Appointed a CASA Volunteer or Control Group for Within-County Analyses

	No CASA Appointment	CASA Appointment
Number of Placement Changes	1.312 (1.074, 1.604)	1.209 (1.098, 1.330)
Probability of Being in an OOHP	0.683 (0.609, 0.750)	0.523 (0.463, 0.583)
Probability of having Re-entered by One Year	0.074 (0.046, 0.101)	0.492 (0.320, 0.620)
Probability of Reunification	0.085 (0.037, 0.184)	0.265 (0.218, 0.318)
Probability of Permanency Placement	0.418 (0.280, 0.570)	0.878 (0.830, 0.914)
Timely Well-Child Visits per Year		
Three Years or Less	2.531 (2.045, 3.132)	3.034 (2.828, 3.255)
Greater than Three Years	1.116 (0.914, 1.362)	0.926 (0.832, 1.030)
Number of Preventable ED Visits per Year	1.100 (0.930, 1.302)	1.007 (0.931, 1.090)

Intervals are 95% confidence intervals