RESEARCH REPORT

LifeSet Evaluation Baseline Data Analysis

Supporting Evidence Building in Child Welfare

OPRE Report 2024-329

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September 2024

CWEST | CHILD WELFARE EVIDENCE STRENGTHENING TEAM

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Executive Summary

Each year, around 20,000 young adults age out of foster care, meaning they left foster care solely due to their age.[1] Many young adults who age out experience poor outcomes such as homelessness, unemployment, lack of education, incarceration, and untreated mental health and substance use problems (Courtney et al. 2020). Unfortunately, the evidence base for interventions that effectively meet the needs of young people leaving foster care is extremely limited.

As part of a larger project aimed at increasing the number of evidence-supported interventions for the child welfare population, the Supporting Evidence Building in Child Welfare project designed a rigorous evaluation of the LifeSet program, a program that provides young adults leaving foster care with intensive community-based support and guidance to make a successful transition to adulthood. A prior evaluation of the LifeSet program showed positive findings at treatment end (Skemer and Valentine 2016). We designed the current evaluation to rigorously test the impact of the program on longer-term outcomes.

Our evaluation used a randomized controlled trial (RCT) design to learn whether LifeSet produces better outcomes than services as usual for young adults in extended foster care in New Jersey. We also conducted an implementation study to understand how LifeSet was carried out in New Jersey and perceptions of the program from young adults, program staff and administrators, and state child welfare administrators. This report provides a description of young people randomized in the study at baseline, characteristics of young adults in the treatment group who enrolled in LifeSet, and perceptions of the LifeSet program from young people, program staff, and state child welfare administrators.

Description of Young People at Randomization and LifeSet Enrollment

We analyzed characteristics of our study sample (n = 661) at randomization (i.e., baseline) and at LifeSet enrollment using administrative data from New Jersey's Department of Children and Families (DCF). A baseline survey collected baseline indicators of outcomes (e.g., education level, employment history,

[1] "Children Exiting Foster Care by Exit Reason," Kids Count Data Center, Annie E. Casey Foundation, June 2021, accessed September 10, 2024, https://datacenter.aecf.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=1&loct=1#detailed/1/any/false/2048,574,1729,37,871,870,573,869,36,868/2631,2636,2632,2633,2630,2629,2635,2634/13050,13051.

behavioral health problems and service use, prior arrests, etc.). Program administrative data from Youth Villages, the developers of LifeSet, provided dates of enrollment in the LifeSet program for young adults in the treatment group.

Survey Responses Suggest Many Young Adults in the Study Experience Challenges but Also Have Strengths to Build On

- We analyzed survey responses from young adults in both the treatment and control groups soon after randomization.
- Almost one-third of baseline survey respondents (30 percent) reported being homeless or couch surfing in the past 12 months, indicating at least one instance of recent housing instability at baseline for a notable portion of respondents.
- Of the 28 percent of young adults who did not have a high school diploma, more than half (62 percent) were currently enrolled in school at the time they completed the survey. Of the 72 percent who had at least a high school diploma, 48 percent were enrolled in school. School enrollment included high school diploma or GED classes, postsecondary education (two- and four-year), and other types of education or training programs, such as trade or vocational school and certificate programs.
- Fifty-seven percent of survey respondents reported working at a full- or part-time job.
- Notably, 45 percent of young adults reported receiving mental health treatment in the past 12 months and 23 percent reported using drugs in the past 30 days.

The Randomization Process in New Jersey Resulted in Treatment and Control Groups That Had Generally Equivalent Characteristics at Baseline

- Most young adults randomized were female (61 percent) and either Black (44 percent) or Hispanic (32 percent). The average age at randomization was 19.4 years. Age at randomization was the only demographic characteristic of statistical nonequivalence, with the treatment group about two months younger than the control group at randomization. The groups were equivalent with respect to sex and race/ethnicity.
- The average age at first removal (i.e., entry into foster care) was 10.7 years (*SD* = 6.1). Young adults experienced an average of 1.7 removals, though 5 percent received child welfare services but never experienced removal. The average age at the most recent removal was 15.1 years (*SD* =

3.5). The average time between young adults' most recent removal and randomization was slightly more than 4 years (*M* = 51.7 months), with young people spending a little less than half of that time in a foster home (*M* = 20.3 months). The treatment and control groups were statistically equivalent on all measures of child welfare history, including total number of removals, lifetime months in placement and in various types of placements, age at first and most recent removal, termination of parental rights and adoption, and most recent discharge reason.

For Young People Randomized to the Treatment Group, Two-Thirds Enrolled in LifeSet

- As of February 2024 (nearly a year since randomization concluded), 68 percent of young adults in the treatment group had enrolled in LifeSet, with 10 percent still receiving LifeSet services. There were no significant differences in enrollment rates across implementing organizations.
- The average time from randomization to enrollment was 31 days and a median of 13 days. There were no significant differences in average time to enrollment across implementing organizations. However, one implementing organization's median time from randomization to enrollment was 22 days, which was significantly longer than the other three implementing organizations' medians.

Young Adults Who Enrolled in LifeSet Were Slightly Older and Spent Less Time Placed with Kin Than Those Who Did Not Enroll

- Young adults who enrolled in LifeSet were about two months older at the time of randomization than those in the treatment group who chose not to enroll, and this difference was statistically significant. The average age of young adults who enrolled in LifeSet was 19.4 years, and the average age of those who chose not to enroll was 19.2 years. There were no significant differences between enrollees and nonenrollees with regard to sex and race/ethnicity.
- Young adults who enrolled in LifeSet spent significantly less time placed with kin during their most recent removal than young adults who did not enroll. Enrolled young people spent an average of five months placed with kin compared with an average of nine months for those who did not enroll. There were no other significant differences related to young adults' child welfare history.

Key Findings from Discussions with Young Adults and Agency Staff

We conducted interviews and focus groups with staff from DCF, Youth Villages, and the implementing organizations, and with young adults randomized to the treatment group to gather their perspectives on LifeSet's implementation. We also examined information from Youth Villages on implementation fidelity collected as part of the LifeSet implementing organizations' certification reviews.

LifeSet Differs From Usual Services in Several Key Ways

- Staff felt that LifeSet's scope and flexibility, program goals, higher frequency of communication with young adults, and well-defined model were key features that distinguish it from services as usual.
- In our focus groups, young adults perceived LifeSet as being more attentive to their goals and wants than other programs. Young adults we spoke with often described LifeSet as a program that "listens to them" in terms of case planning and goal setting.

Staff Used Multiple Methods to Recruit and Enroll Eligible Young Adults in the LifeSet Program

- **DCF identified which young adults were eligible for LifeSet through a centralized referral process.** DCF staff stated that this was the first time the Office of Adolescent Services (OAS) had instituted a centralized referral process for a service. While the evaluation was the primary reason a centralized process was used for LifeSet, interviewees stated that the experience had led them to consider applying it to other services.
- **Referrals were assigned based on LifeSet specialists' caseloads.** LifeSet supervisors stated they tried to consider factors such as the young adult's demographics (e.g., gender, Spanish speaking) and location relative to other young people on specialists' caseloads when assigning referrals. However, they stated that referrals were often assigned based on which specialist had capacity at the moment.
- **Contact with DCF caseworkers was at the specialists' discretion.** Some specialists would contact a young adult's DCF caseworker to get more information as they found this could be useful in encouraging young people to enroll by highlighting a specific need or interest that

LifeSet could support. Other specialists preferred to have a "blank slate" of sorts when entering conversations with young adults.

- A common recruitment tactic was focusing on how LifeSet is unique. Program staff stated that young adults may initially perceive LifeSet as just another program and thus not see much value in participating. One strategy used to engage young adults was to focus on how LifeSet is unique and not a duplication of other services.
- Specialists had mixed feelings about doing pop-ups. Specialists and supervisors mentioned that the LifeSet licensed program experts encouraged them to conduct unannounced visits to young adults' residences (referred to as "pop-ups") to engage referred young people who had not responded to calls or texts to enroll. Staff we spoke with expressed mixed feelings about doing pop-ups. Some felt that the pressure to conduct pop-ups, especially multiple times after young adults had declined LifeSet, was at odds with the program's philosophy of being youth driven.

LifeSet Is Being Delivered as Youth Villages Intended, with Some Minor Modifications during the COVID-19 Pandemic

- Youth Villages has conducted four certification reviews for each implementing organization in New Jersey. For all four certifications, the New Jersey organizations met the minimum thresholds with overall scores ranging from 84 percent to 95 percent, suggesting LifeSet is being implemented with fidelity in New Jersey.
- Staff interviews also suggest that LifeSet is being implemented as intended. Descriptions of the program provided by staff align with core aspects of the program, including the LifeSet team structure, individual and group supervision, and clinical consultation. Young adults in the treatment group for LifeSet also described the program in a way that confirms fidelity, such as having weekly meetings with their specialist at home or in the community and setting and working toward their personally defined goals.
- The use of virtual sessions is one area in which implementation was modified in New Jersey. Youth Villages allowed specialists to conduct weekly sessions with young adults virtually in 2021 through 2022 due to the COVID-19 pandemic. By 2023, Youth Villages had reinstated the requirement that only in-person sessions would count toward fidelity. However, specialists stated that young adults would ask to meet virtually as it fit better with their school or work schedules. Specialists sometimes acquiesced to young adults' requests, viewing a virtual session as better than no session.

Methods

To evaluate the LifeSet program, we implemented a randomized controlled trial (RCT) design. An RCT was chosen because the design provides the best evidence as to whether a program works and because the target population for the LifeSet program included many more people who were eligible for the intervention than could be served by the program's limited slots. The evaluation therefore allocated the limited program slots by lottery, which is a fair way to allocate scarce resources. Young people ages 17 to 21 in an out-of-home placement or young adults ages 18 to 21 who had an open voluntary services case with DCF, were living in the community, and did not have a disqualifying condition were eligible for the LifeSet program. Randomization of young people occurred from August 2021 through March 2023. Only young people randomized to the treatment group received a referral to LifeSet. Young people in the control group continued to receive referrals to other services as usual. Baseline surveys were collected by trained interviewers after randomization. The overall baseline survey response rate was 60 percent. We also collected child welfare administrative data from DCF and LifeSet program administrative data from Youth Villages. We conducted baseline equivalence tests using DCF administrative data. We examined enrollment rates using the LifeSet program data, and we utilized certification scores for the LifeSet implementing organizations to assess whether LifeSet was delivered as intended in New Jersey.

Next Steps

Urban is conducting a follow-up survey through grant funding from Youth Villages. The survey will be administered at approximately 24-months postrandomization to all randomized young people, regardless of whether they responded to the baseline survey. We may also receive administrative data from additional sources to assess outcomes such as incarceration, public benefits receipt, education, and employment. We will conduct our impact analyses in accordance with our preregistered analytic plan. We expect to publish the final impact study report in late 2026.

LifeSet Evaluation Baseline Data Analysis

The purpose of this report is to share early findings from an evaluation of the LifeSet program in New Jersey. The evaluation used a randomized controlled trial (RCT) design to learn whether LifeSet produces better outcomes than services as usual for young adults in extended foster care. Outcomes of interest included education and employment, social connections, housing stability, youth well-being, mental health, criminal justice involvement, intimate partner violence, and economic well-being.

This report provides a description of young adults randomized in the study drawn from child welfare administrative data and a baseline young adult survey as well as an initial analysis of treatment and control group equivalence using child welfare administrative data. We also present early findings on the treatment group's enrollment in LifeSet, including enrollment rates and characteristics of young adults in the treatment group who enrolled in the program. Finally, we summarize information about LifeSet's implementation gathered through discussions with program staff and administrators, state child welfare administrators, and young adults in the study.

Supporting Evidence Building in Child Welfare Project

As part of a larger project aimed at increasing the number of evidence-supported interventions for the child welfare population, the Supporting Evidence Building in Child Welfare project[2] designed a rigorous evaluation of the LifeSet program, a program that provides young adults leaving foster care and other transition-age young people who are at high risk of negative outcomes with intensive in-home support and guidance to make a successful transition to adulthood. Each year, around 20,000 young adults age out of foster care, meaning they left foster care solely due to their age.[3] Many young

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[2] "Supporting Evidence Building in Child Welfare: 2016–2025," US Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Office of Planning, Research, and Evaluation (OPRE), accessed September 6, 2024, https://www.acf.hhs.gov/opre/project/supporting-evidence-building-child-welfare-2016-2025.

[3] "Children Exiting Foster Care by Exit Reason," Kids Count Data Center, Annie E. Casey Foundation, June 2021, accessed September 10, 2024, https://datacenter.aecf.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=1&loct=1#detailed/1/any/false/2048,574,1729,37,871,870,573,869,36,868/2631,2636,2632,2633,2630,2629,2635,2634/13050,13051.

adults who age out experience poor outcomes such as homelessness, unemployment, lack of education, incarceration, and untreated mental health and substance use problems (Courtney et al. 2020).

Unfortunately, the evidence base for interventions that effectively meet the needs of young adults aging out of foster care is extremely limited. This shortage of evidence prevents public and private agencies from implementing evidence-based practices and programs. A prior evaluation of the LifeSet program showed positive findings at treatment end (Skemer and Valentine 2016). We designed the current evaluation to rigorously test the impact of the program on longer-term outcomes. Positive findings from an additional RCT with a longer post-treatment follow-up could move LifeSet from "promising" to "supported" or "well-supported" status, according to the standards of the Title IV-E Prevention Services Clearinghouse[4] (the Clearinghouse) and the California Evidence Based Clearinghouse for Child Welfare (CEBC).[5]

To investigate the LifeSet program, we implemented an RCT design. The RCT design allows us to draw causal conclusions and compare the trajectories of young adults who receive LifeSet services with those of similar young adults who receive usual services. We also conducted an implementation study to understand how LifeSet was carried out in New Jersey and perceptions of the program from young adults, program staff and administrators, and state child welfare administrators.

This descriptive report provides characteristics of the sample at baseline (i.e., randomization) and enrollment in LifeSet services—to its final impact. Due to delays in establishing an evaluation site, the Supporting Evidence Building in Child Welfare project included only randomization and collection of baseline data. The Urban Institute received funding from Youth Villages, Inc., to complete an impact evaluation examining impacts at 24 months post-randomization. Results are anticipated to be published in 2026.

Research Questions and Data Sources

Table 1 presents our research questions and data sources for the baseline analysis. Data sources used to answer the research questions included a baseline young adult survey, child welfare administrative data from the New Jersey Department of Children and Families (DCF), LifeSet program administrative

[4] Title IV-E Prevention Services Clearinghouse, accessed September 6, 2024, https://preventionservices.acf.hhs.gov/.

[5] California Evidence-Based Clearinghouse for Child Welfare, accessed September 6, 2024, https://www.cebc4cw.org/.

data from Youth Villages, and interviews and focus groups with program administrators, supervisors, frontline staff, and young adults in the study.

TABLE 1

Research Questions and Data Sources

Research question	Child welfare administrative data	LifeSet program data	Baseline young adult survey	Interviews and focus groups
Did the randomization process in New Jersey result in treatment and control groups with equivalent characteristics at baseline?	X			
For young adults randomized to the treatment group, what was the rate of enrollment in LifeSet?		X		
For young adults randomized to the treatment group, what characteristics distinguish those who enrolled in LifeSet from those who did not?	X	X	X	
How does LifeSet differ from usual services?				X
How are eligible young adults identified, recruited, and enrolled in the LifeSet program?				X
Is LifeSet being delivered as Youth Villages intended, or are there modifications being made for the New Jersey context?		X		X

Source: LifeSet evaluation project team.

The study used an RCT design to determine which young adults would receive a referral to LifeSet (the treatment group) and which young adults would continue receiving services as usual (the control group). The target population for the LifeSet program included more people who needed, and were eligible for, the intervention than could be served by the program. The evaluation therefore allocated the program slots by lottery, which is a fair way to allocate scarce resources. DCF staff identified eligible young adults by reviewing administrative data and screening discussions with caseworkers. We used administrative data from DCF to describe the study young adults' demographic characteristics (i.e., age, sex, race/ethnicity) and child welfare history (e.g., number of removals, placement types, time in care). Trained field interviewers conducted baseline young adult survey interviews by phone and in person with young people after randomization. The baseline survey collected information about young adults' demographic characteristics and baseline indicators of outcomes (i.e., education level, employment history, housing stability, economic well-being, behavioral health problems and service use, prior arrests, perceived level of social support, pregnancy and parenting status, youth resilience and social-emotional competence, victimization of partner violence, and experience with transition services). Program administrative data from Youth Villages provided dates of young adults' enrollment in LifeSet and information on implementation fidelity collected as part of the program's certification

reviews. Finally, interviews and focus groups were conducted with staff from DCF, Youth Villages, and the implementing organizations, and with young adults randomized to the treatment and control groups to gather their perspectives on LifeSet's implementation (research questions d–f). We explain our methods and study design in more detail in the "Methods" section of this report.

Description of the Intervention

The LifeSet program was developed by Youth Villages, Inc., a private nonprofit organization. LifeSet provides transition-age young people leaving foster care, juvenile justice, and mental health systems with intensive community-based support and guidance to help them make a successful transition to adulthood. Young adults with mental health problems that render them a threat to the safety of themselves or others, intellectual disabilities, and/or histories of serious violent criminal behavior are not considered appropriate for LifeSet services. At its core, the program is a therapeutic relationship between the young adults and LifeSet specialists who work with them to develop and move toward goals defined by the young adults in multiple domains of independent living.

Youth Villages operates LifeSet in 12 states, and the organization trains and supports nonprofit partners to offer LifeSet in 11 additional states.[6] The current study evaluated the LifeSet program in New Jersey where four nonprofit local agencies were contracted by DCF to deliver LifeSet starting in September 2020.

Program Services

The LifeSet program provides supports and services in multiple domains of independent living:

- attaining secondary or postsecondary education or training
- securing safe, stable, and affordable housing
- learning about physical and mental health, including sexual health and pregnancy prevention
- managing employment, economic security, and finances
- avoiding negative legal involvement

[6] Youth Villages directly provides LifeSet in Alabama, Arizona, Arkansas, Georgia, Kentucky, Massachusetts, Mississippi, New Hampshire, North Carolina, Oklahoma, Oregon, and Tennessee. LifeSet is provided by approved nonprofits in Connecticut, Illinois, Louisiana, Missouri, Nevada, New Jersey, New York City, Ohio, Pennsylvania, Washington, and Washington, DC. See "LifeSet," Youth Villages, accessed September 6, 2024, https://youthvillages.org/services/lifeset/.

- building a positive social support network, including a focus on lifelong connections with caring adults

It is structured around a core relationship between each young adult and their assigned LifeSet specialist who works intensively with them throughout their time in the program. The LifeSet specialist works with the young adult to develop an individualized plan based on the young person's personal context and goals. During the initial assessment and goal-setting process, the LifeSet specialist engages people and systems involved in the young adult's life.

The young adult and LifeSet specialist meet at least weekly in-person, usually for one hour. During weekly sessions, the LifeSet specialist provides clinically focused support, counseling, and assistance accessing other services aimed at helping the young adult move toward their goals. These meetings occur in a community setting, either at the young adult's home, work, or at whatever other location is most comfortable and convenient for them. In addition to the regular, scheduled meetings, young people are able to get in touch with a LifeSet specialist 24 hours a day, 7 days a week. Youth Villages recommends young adults spend between 6 and 12 months in the program and reports that participants generally spend around 7 to 9 months in the program across jurisdictions where the program is currently in operation.

Program Staffing

Program staffing consists of three main staff positions: (1) LifeSet specialists, (2) team supervisors, and (3) licensed program experts. A LifeSet team consists of a supervisor and their assigned specialists. LifeSet specialists work with 8 to 10 young adults at any one time and have either a master's degree in a relevant field or a bachelor's degree and relevant work experience. Team supervisors supervise up to four LifeSet specialists and have a master's degree in a relevant field or a bachelor's degree with relevant work experience. The supervisor role includes conducting group supervision, carrying out individual and field supervision, and creating and monitoring professional development plans for all team members. Lastly, licensed program experts are responsible for ensuring model fidelity and providing clinical guidance to four to five LifeSet teams. Licensed program experts ideally have LifeSet implementation experience at the specialist and supervisor levels and hold a master's degree and professional license in a social service field.

Essential Program Components

Essential program components include the following:

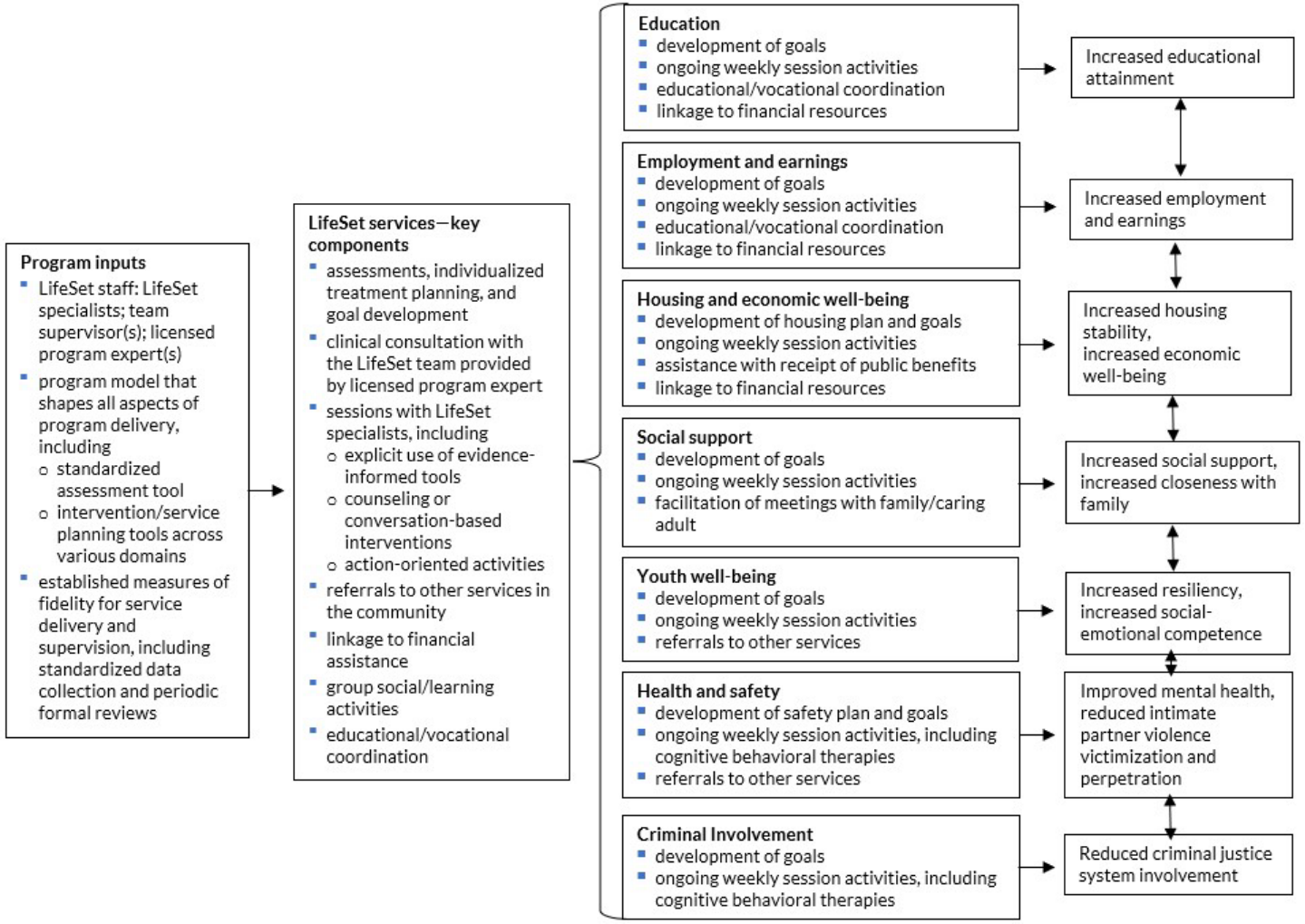
- small caseloads of 8 to 10 young adults per LifeSet specialist
- minimum of weekly face-to-face contact between LifeSet specialists and young adults, plus 24-7 access to a LifeSet trained staff member for crisis support
- an explicit use of GuideTree®,[7] an online platform that provides evidence-informed tools, counseling or conversation-based interventions, and action-oriented activities during weekly sessions
- individualized goal development and treatment planning
- a structured program model including guidelines around assessment, interventions, measures of fidelity, standardized data collection, and periodic formal reviews
- clinical consultation with the LifeSet team provided by licensed program experts
- a comprehensive focus on multiple domains of independent living, including accessing financial assistance, group social and learning activities, and coordination with educational and vocational supports
- referrals to other agencies and programs to ensure young adults have access to the supports and services needed to move toward their goals

Figure 1 presents the LifeSet logic model. The logic model outlines the components of the program and the domains they seek to affect. The program aims to affect each of these domains by developing individualized goals and ongoing interactions with the LifeSet specialists as well as other key components specific to the domain. For example, in the education domain, the program offers financial assistance and educational and vocational coordination.

[7] "GuideTree®," Youth Villages, accessed September 9, 2024, https://guidetree.youthvillages.org.

FIGURE 1

LifeSet Logic Model



Source: Youth Villages.

Description of Services as Usual

Services as usual in New Jersey for teenagers and young adults ages 14 to 21 in foster care include a variety of program types and domains, as listed in table 2. This service array is funded through both federal Chafee[8] funding and state sources. These services were available to both the control and treatment groups.

TABLE 2

New Jersey Services Specific to Transition-Age Young People in Foster Care

Domain	Program	Description
Housing	Various housing programs	Nonclinical housing options accessed through the Adolescent Housing Hub that provide safe and stable housing with the goal of assisting young adults ages 18 to 21 to achieve self-sufficiency and a successful transition to adulthood. Various transitional and subsidized housing programs are also available. These programs provide supportive services and case management to teenagers and young adults in addition to housing.
School/work success	Pathways to Academic and Career Exploration to Success (PACES) coaching services	Program helps teenagers and young adults in foster care with effective transition-planning practices to obtain a high school diploma and engage in postsecondary education, career exploration, vocational training, and other services and supports as necessary to secure employment.
	New Jersey Foster Care Scholars (NJFCS) Program	Provides funding for eligible foster, adoptive, kinship, and homeless teenagers and young adults to pursue a postsecondary education at an accredited two- or four-year college, university, or trade or career school. This is the state's Chafee Education and Training Voucher (ETV) program.
Age-appropriate developmental skills	Life Skills	Instruction in daily living domains, such as budgeting and financial management, communication, decisionmaking, self-care, and housing for young people in out-of-home placement ages 14 to 21. Assistance in obtaining a high school diploma, career exploration, vocational training, job placement, and job retention are also included.
Financial assistance	Independent living stipend	The independent living stipend is available to eligible teenagers and young adults ages 16 to 21 who need additional financial assistance as they transition to adulthood.
	Foster Care Scholars Gap Housing	Provides housing for breaks and the summer for NJFCS recipients.
	Medicaid coverage	Medicaid is available to teenagers and young adults who are in an out-of-home placement. Under the Affordable Care Act, young adults with foster care experience may be eligible to receive Medicaid until age 26.

Source: New Jersey Department of Children and Families.

[8] John H. Chafee Foster Care Program for Successful Transition to Adulthood (the Chafee program).

Housing

DCF offers several housing options for young adults ages 18 to 21. Young adults can remain in the home of a resource parent (i.e., foster parent or kinship caregiver) or in a congregate placement (i.e., residential treatment or group home) while in extended foster care. In such instances, young people are not eligible to receive the independent living stipend, and either a resource board rate continues to be provided by DCF to the caregiver or DCF contracts with the congregate care agency for payment. DCF also offers transitional-living programs, some of which are supervised, in which young people live in their own or a shared apartment either rent-free or on a sliding scale based on income.

Transitional-living programs are operated by community implementing organizations and offer housing and support services that are transitional and time limited. Some of the transitional-living programs are supervised and licensed and have rules such as curfews. Additionally, the DCF youth housing array contains youth supportive housing programs that combine subsidized housing with voluntary support services. Young adults in any of these settings may be eligible for the independent living stipend depending on need and what the program provides.

Despite multiple options, not enough program slots exist for all young adults in need of housing. Young people who are not able to live with a resource parent or in supervised or transitional housing often must find market rate housing. They may also apply for federal housing vouchers or other state and local housing assistance if they qualify, though such programs have long waitlists.

Other DCF Services

Additional DCF-supported services and general assistance are available to transition-age young people in New Jersey that those in foster care may also access. These include but are not limited to

- behavioral or mental health and substance use services offered through the Children's System of Care,
- parenting supports (e.g., home-visitation programs and Family Success Centers) through Family and Community Partnerships, and
- domestic and sexual violence specific services through the Division on Women.

DCF can also access emergency funding to support young adults who no longer have a case open with the child welfare system.

Other General Services

Young adults in extended foster care are also eligible for many other services provided by other public and private agencies, such as the Supplemental Nutrition Assistance Program, child care vouchers, job training, and mentoring. DCF works closely with other state agencies (e.g., Department of Community Affairs, Office of Higher Education, and the Department of Labor and Workforce Development) and community-based agencies to leverage resources and services to support transition-age young people.

Methods

Below is a summary of our methods. Appendix D provides additional details about the study methods.

Study Design

We used a randomized controlled trial to understand the causal impact of LifeSet services on New Jersey young adults in the target outcome domains of

- connections to education and employment,
- social connections,
- housing stability, and
- youth well-being (resilience and social-emotional competence).

Study Sites

The evaluation covered 18 of New Jersey's 21 counties, which account for more than 98 percent of young people ages 17 to 21 in care.[9] Implementation of LifeSet in New Jersey consisted of four private local implementing organizations who each had one LifeSet team composed of four specialists and a supervisor. Table 3 displays the LifeSet organizations' county coverage.

TABLE 3

LifeSet Implementing Organizations' County Coverage

Organization	Counties covered
Region A	Atlantic, Camden, Cape May, Cumberland, Gloucester, Salem
Region B	Essex, Mercer, Middlesex, Somerset, Union
Region C	Bergen, Essex, Hudson, Morris, Passaic
Region D	Burlington, Camden, Monmouth, Ocean

Source: New Jersey Department of Children and Families.

[9] The excluded counties were Sussex, Warren, and Hunterdon counties.

Target Population

The target population for LifeSet in New Jersey was young people ages 17 to 21 who had an open case with DCF, were living in the community (i.e., not incarcerated, in residential treatment, or hospitalized), were living in the counties served by the implementing organizations, and did not have a disqualifying condition (i.e., serious violent criminal history, severe mental illness, or intellectual disability). An open case meant that the young adult was receiving services from DCF through a voluntary services agreement (for young adults ages 18 to 21) or were in the custody or guardianship of DCF (if age 17). Young people could enter into a voluntary services agreement if they are receiving services from DCF, either in home or in foster care, at age 16 or older and do not have legal permanency at the time of entering the agreement.[10]

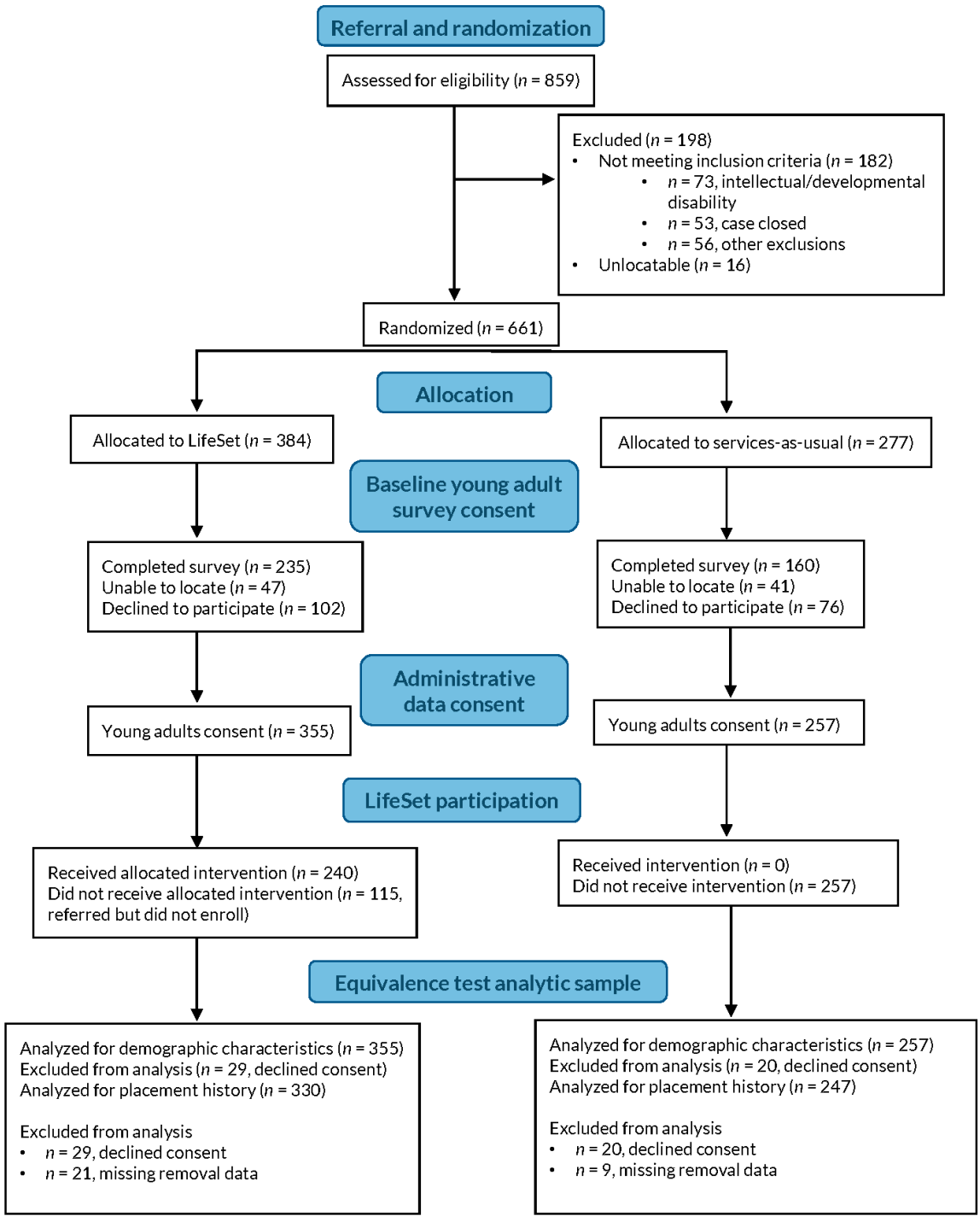
Referral and Randomization Strategy

Figure 2 shows the flow of participants in the study. Referral and randomization to the program occurred from August 2021 to March 2023. DCF used its administrative data to identify young people who met the age criteria for LifeSet, had an open services case, and lived in one of the target counties. An administrator in DCF's OAS then conducted a secondary screening by contacting caseworkers to confirm that the young adult did not meet any exclusion criteria.

[10] Young adults who received only in-home services from DCF can choose to continue receiving services after age 18. For more details on voluntary services eligibility, see DCF policy CPP-III-A-1-500 in the "New Jersey Department of Children and Families Policy Manual," September 24, 2012, https://dcfpolicy.nj.gov/api/policy/download/CPP-III-A-1-500.pdf.

FIGURE 2

Flow Diagram of Study Participants



Source: New Jersey Department of Children and Families screen-out data.

Notes: Other exclusion reasons included incarceration, not residing in the service area, severe mental or behavioral health issues, or unspecified "other" reasons. Study consent and LifeSet enrollment did not always occur sequentially; some young adults enrolled in LifeSet before providing study consent (see appendix D for details).

DCF sent the list of eligible young adults and the number of study slots needed per region to the Urban project team, who performed the random assignment and sent back to DCF the list of young adults with their group assignments. DCF then referred young adults in the treatment group to a LifeSet implementing organization; those in the control group were referred to, or continued receiving, services as usual. As noted above, usual services were also available to the treatment group.

Randomization began in August 2021 using a 1 treatment to 1 control (1T:1C) ratio, stratified by implementing organization. Due to lower than anticipated enrollment among the treatment group, we changed the randomization ratio in March 2022 within each organization stratum to 2T:1C to fill program slots while still maintaining a randomized control group. We randomized a total of 661 eligible young adults with 384 of them assigned to the treatment group and 277 assigned to control group.

Data Sources and Measures

Baseline Young Adult Survey

The baseline survey included demographics and baseline indicators of outcome measures and information needed to contact young people for follow-up surveys. The survey included pretest measures of outcomes in multiple domains that were unavailable in child welfare administrative data, such as current employment and income, education level, school enrollment, housing stability, and social relationships. Additionally, the baseline survey contained items that can be used as covariates in future impact analyses, such as parenting status and history of homelessness, substance use, and criminal justice involvement. Items for the baseline survey were drawn primarily from the CalYOUTH survey.[11] We measured the domains of youth resilience and social-emotional competence using two sections from the Youth Thrive™ Survey. We also used items from the Conflict Tactic Scale (CTS) to assess young adults' engagement in or experience of intimate partner violence.

SURVEY COLLECTION PROCEDURES

Due to the COVID-19 pandemic, from November 2021 into August 2022 survey outreach was conducted solely by postal mail, phone, and email, and all interviews were conducted by phone. In-

[11] The CalYOUTH Wave 2 survey instrument was provided to the study team by Dr. Mark Courtney.

person survey outreach and collection occurred from August 2022 through end of collection in June 2023. Informed consent was obtained orally for both phone and in-person survey interviews. Young people received a copy of the informed consent form either via mail (for phone interviews) or in person. The interviewer reviewed the consent form verbally with the participant, answered any questions the participant had, documented the participant's consent status, and proceeded with the survey interview for those who consented. Half of respondents completed the survey about 2.5 months after randomization with a mean of about 3.5 months (table D.5).

Survey Response Rates

The overall baseline survey response rate was 60 percent, and there were no major differences between respondents and nonrespondents (table D.3). Response rates were similar between the treatment and control groups (61 percent versus 58 percent). Overall response rates were similar for three of the four implementing organization areas (61 percent to 66 percent), with one region lower at 52 percent (table D.4).

DCF Administrative Data

We received administrative data related to demographics and child welfare history from DCF for young adults in the study who did not actively decline consent for the research team to access their administrative data. The administrative data received included demographics, removal and placement dates, removal reasons, discharge reasons, placement types, and receipt of independent living stipends.

DATA QUALITY

We assessed the quality of the DCF administrative data by examining rates of item and unit (i.e., youth-level) missingness and assessing date logic where applicable. Thirty young adults had no removal dates (5 percent of sample), and data for an additional six young adults (1 percent) indicated their first removal episode occurred after age 18. Conversations with DCF confirmed that in 29 cases young adults had never been removed (i.e., placed in DCF custody), and in one case data were not accessible to New Jersey DCF. These 30 young adults were excluded from analyses related to removal and placement history.

Youth Villages Program Data

We received program data from Youth Villages related to LifeSet enrollment for young adults in the study and certification scores for the four LifeSet implementing organizations.

CERTIFICATION SCORES

Youth Villages conducts an initial six-month certification review of agencies that provide LifeSet, followed by annual reviews. These annual certifications contain two subscores—one focused on operations and another on clinical implementation—that are combined into an overall score. The clinical subscore includes a review of cases within a random six-month period of the past year. Documentation is reviewed related to group supervision, staff development, service plans, and safety plans, and young adults and staff are surveyed. The operations score reviews an entire year's performance. It mostly consists of LifeSet's key performance indicators (KPI), but also includes items related to risk and financial management (e.g., workers' compensation, compliance documents) and program sustainability.

The maximum score both overall and on each subscale is 100. An overall score of 80 percent is the minimum required for a partner agency to be considered implementing LifeSet with fidelity. Agencies are also expected to meet the 80 percent threshold for every individual measure scored, with the exception of two operations measures, related to sessions held and full staffing, that must meet a 90 percent threshold. Per Youth Villages, the average certification scores across all partners and review types since 2020 were 85 percent overall, 86 percent for the clinical subscore, and 81 percent for the operations subscore.

Interview and Focus Group Data

We conducted interviews and focus groups with program administrators, LifeSet staff, and young adults in the treatment group to gather their perspectives on the implementation of LifeSet in New Jersey. All interviews and focus groups used semistructured protocols led by Urban researchers. We conducted multiple interviews and focus groups with staff and administrators in the following roles: program managers at the LifeSet implementing organizations, LifeSet supervisors, LifeSet specialists, Youth Villages' licensed program experts and other clinical directors assigned to the New Jersey organizations, administrators within Youth Villages' research and strategic partnership teams, DCF caseworkers who had young adults on their caseload in the treatment group, and administrators in DCF's OAS and Office of Applied Research and Evaluation. Finally, we conducted individual and paired interviews with 11 young adults in the treatment group who had received LifeSet and 3 young adults in the control group.

Understanding the Young Adult Sample

In this section we present findings for research questions a–c in table 1 related to the characteristics of young adults that enrolled in LifeSet, rate of LifeSet enrollment, and baseline equivalence. We present findings for research questions related to LifeSet's implementation in New Jersey in the "Understanding LifeSet Implementation" section.

Sample Description

We present a description for the full sample using administrative and baseline survey data in table 4. Demographic characteristics are presented below using DCF administrative data. The majority of young people randomized were female and either Black or Hispanic. Appendix C provides the sample demographic characteristics by region.

TABLE 4

Full Study Sample Demographic Characteristics

	N	Mean/%
Race/ethnicity		
Black, not Hispanic	267	44%
White, not Hispanic	125	20%
Other race, not Hispanic	26	4%
Hispanic, any race	193	32%
Age at randomization[a]	661	19.4
Sex		
Female	368	61%
Male	239	39%

Source: New Jersey Department of Children and Families administrative data.

Note: Data for race/ethnicity and sex exclude 49 young adults who declined consent to access their administrative data and 1 young adult who declined to share their race/ethnicity in the administrative data.

[a] The standard deviation for age was 0.89.

The survey included items for young people to provide their sex assigned at birth, [12] gender identity, and sexual orientation. For those who responded to the survey, self-reported sex aligned well with the DCF administrative data (appendix B). We present survey data on gender identity and sexual orientation in table 5. For the woman and man categories, we combined cisgender and transgender respondents. The majority of respondents identified as women and heterosexual. About one-fifth of respondents identified as bisexual, pansexual, or asexual, or specified another sexual orientation.

TABLE 5

Gender Identity and Sexual Orientation of the Full Sample of Survey Respondents

	N	*%*
Gender identity	392	
Woman	245	63%
Man	139	35%
Nonbinary, other genders	8	2%
Sexual orientation	390	
Heterosexual	285	73%
Homosexual	24	6%
Other orientation	81	21%

Source: LifeSet evaluation baseline young adult survey.

We used DCF administrative data to describe the young adults' removal and placement experiences before randomization. A removal episode begins when a child, teenager, or young adult is removed from their home and placed in out-of-home care by DCF. A placement episode begins when a child, teenager, or young adult is initially placed in an out-of-home placement or when they move from one out-of-home placement to a different out-of-home placement. A person can have multiple placement episodes within one removal episode. Among the 612 young adults in the administrative data sample, 30 young adults had no removal dates in the DCF administrative data and were excluded from analyses related to removal and placement history. Therefore, 582 total young adults are included in the most recent removal analyses in table 6.

Randomized young adults experienced an average of 1.7 removals, though 5 percent had never been removed. The mean age at first removal was a little under 11 years old while the mean age at the most recent removal was 15 years. The mean time young adults had been in care before randomization

[12] Throughout this report we use "sex" when referring to biological classification of male or female in the DCF administrative data. We use "gender" when referring to respondents' self-reported gender identity as man, woman, or nonbinary from the baseline young adult survey.

was a little more than 4 years. Young people spent the largest share of their most recent removal in a foster home placement.

TABLE 6

Full Study Sample Child Welfare History

	N	Mean (*SD*)/%
Lifetime experience		
Age at first removal	582	10.7 (6.1)
Total number of removals	612	1.7 (1.0)
Never removed	30	5%
Total months in care	612	46.4 (36.0)
Experienced TPR	51	8%
Most recent removal[a]		
Age at last removal	582	15.1 (3.5)
Months between most recent removal start date and randomization date	582	51.7 (41.7)
Total months in congregate care[b]	582	4.1 (12.2)
Total months in congregate care for those who spent any time in congregate care	153	15.7 (19.8)
Total months in foster home[c]	582	20.3 (25.7)
Total months in foster homes for those who spent any time in foster homes	394	30.1 (26.1)
Total months in kinship care[d]	582	6.2 (11.9)
Total months in kinship care for those who spent any time in kinship care	222	16.1 (14.4)
Total number of placements	582	3.8 (4.1)
Removal discharge reason		
Reunification	50	9%
Adoption, guardianship, or other permanent home	136	23%
Aged out	299	51%
Runaway	<10	1%
Other	15	3%
Still in care	74	13%

Source: New Jersey Department of Children and Families administrative data.

Note: Data exclude 49 young adults who declined consent to access their administrative data.

TPR = termination of parental rights.

[a] Data on placement types include time in placements after age 18 up to randomization date. Young adults who were living on their own were often not recorded as being in a placement. Therefore, the months for each placement type do not sum to the total months in care before randomization.

[b] All young adults with a removal history were included in the mean calculation for total months in congregate care. Of the 582 young adults with a removal history, 153 had a congregate care placement during their most recent removal and 429 did not have a congregate care placement.

[c] All young adults with a removal history were included in the mean calculation for total months in foster home. Of the 582 young adults with a removal history, 394 had a foster home placement during their most recent removal and 188 did not have a foster home placement.
[d] All young adults with a removal history were included in the mean calculation for total months in kinship care. Of the 582 young adults with a removal history, 222 had a kinship care placement during their most recent removal and 360 did not have a kinship placement.

The baseline survey included pretest measures of outcomes in multiple domains that were not available in child welfare administrative data, such as employment and income, education level, housing stability, and relationships. The baseline survey also included items to assess characteristics that can be used as covariates in future impact analyses, such as parenting status and history of homelessness, substance use, and criminal justice involvement.

We note several areas of interest from the baseline survey analysis (table 7). Almost one-third of young people (30 percent) reported being homeless or couch surfing in the past 12 months, indicating at least one instance of recent housing instability at baseline for a notable portion of respondents. Of the 28 percent of young people who did not have a high school diploma, more than half (62 percent) were currently enrolled in school at the time they completed the survey. Of the 72 percent who had at least a high school diploma, 48 percent were enrolled in school. School enrollment included high school diploma or GED classes, postsecondary education (two- and four-year), and other types of education or training programs, such as trade or vocational school and certificate programs. Fifty-seven percent of young adults reported working at a full- or part-time job. About 16 percent of young adults reported that they were not working, were not in school, and had no children. Notably, 45 percent of young people reported receiving mental health treatment in the past 12 months and 23 percent reported illicit substance use in the past 30 days.

The survey also assessed young adults' social well-being in the domains of resilience and social-emotional competence using sections from the Youth Thrive™ Survey. The average score on the resilience section was 38.2 out of 50, with a standard deviation of 6.7. Additionally, the average score on the social-emotional competence section was 62.7 out of 80, with a standard deviation of 8.8. The items used to measure resilience and social-emotional competence have not yet been norms-tested for the general population of young adults, so we cannot draw direct conclusions about youth baseline characteristics in these domains. However, these results will be compared with our follow-up survey. Additional information on how these sections were scored can be found in the "Methods" section.

TABLE 7

Baseline Survey Results for the Full Study Sample

Survey item	*N*	Mean (*SD*)/%
Current living arrangement	394	
Own place/room	97	25%
Independent living program	71	18%
In home of parent or relative	78	20%
In home of current/former resource parent	59	15%
Other housed	66	17%
Unhoused	11	3%
Other	12	3%
Housing stability		
Number of moves in past 12 months	386	
0 moves	127	33%
1 move	91	24%
2 moves	71	18%
3 moves	53	14%
4+ moves	44	11%
Homeless or couch surfed in past 12 months	394	
Yes	117	30%
Education		
Current education level	395	
Less than high school	112	28%
High school diploma/GED	165	42%
Some college/technical school	59	15%
Associate's degree/training certificate	59	15%
Currently enrolled in school	395	
Yes	206	52%
Enrolled in secondary school	78	38%
Enrolled in postsecondary school	108	53%
Enrolled in other type of schooling (e.g., vocational)	19	9%
Employment		
Currently working at a full- or part-time job or jobs	394	
Yes	225	57%
Formally employed in the past 12 months[a]	170	
Yes	117	69%
Informally employed in the past 12 months	395	
Yes	126	32%
Neither working nor in school	395	
Yes	77	19%
Income in the past 12 months (in dollars)	369	$8,663 ($12,659)
Fertility		
Pregnant or expecting	394	
Yes	21	5%
Number of children	395	
0 children	337	85%
1 child	43	11%
2 children	11	3%
3+ children	4	1%

Survey item	*N*	Mean (*SD*)/%
Behavioral health		
Received mental health treatment in past 12 months	394	
Yes	178	45%
Substance use		
In past 30 days…		
Binged alcohol (any age)	392	
Yes	48	12%
Used drugs[b]	394	
Yes	91	23%
Received substance use treatment in past 12 months	394	
Yes	10	3%
Criminal justice		
Ever arrested	394	
Yes	91	23%
Ever spent at least one night in jail/prison	392	
Yes	63	16%
Safety		
Experienced domestic violence in past 12 months[c]	182	
Yes	26	14%
Social well-being		
Resiliency scale	395	38.2 (6.7)
Social-emotional competency scale	395	62.7 (8.8)

Source: LifeSet evaluation baseline young adult survey.

[a] Only asked of young adults who were not currently working at a full- or part-time job.

[b] The definition of "drugs" in this case includes any "illegal drugs including marijuana, heroin, cocaine, amphetamines (uppers, speed, etc.), barbiturates (downers), sniffing/huffing, hallucinogens (mushrooms, LSD, acid), club drugs (Ecstasy, Special K, GHB)" or any "prescription drugs without a doctor's permission or beyond what is prescribed." Marijuana was included in the definition of illegal drugs although it is legal in New Jersey for people over age 18.

[c] Module only asked if respondents indicated they were currently in a romantic relationship.

Did the Randomization Process in New Jersey Result in Treatment and Control Groups with Equivalent Characteristics at Baseline?

To assess whether the randomization process in New Jersey worked as intended and resulted in treatment and control groups with equivalent characteristics at baseline, we analyzed demographic data and child welfare history for young adults in the study.[13] We present two assessments of baseline equivalence. First, we present the *p*-value for tests of statistical equivalence where values ≤ 0.05 are

[13] Follow-up survey respondents who were 17 years old when they completed the baseline survey or who did not complete the baseline survey will be asked for consent for administrative data and linkage. While some respondents for whom we had a waiver of consent may decline at that time, we expect this number to be small and not change the overall equivalence findings.

considered nonequivalent. Second, we present the effect size of group differences in line with the baseline equivalence standards of the Title IV-E Prevention Services Clearinghouse (the Clearinghouse). The Clearinghouse considers effect sizes less than 0.05 as equivalent and those between 0.05 and 0.25 as in the adjustment range, meaning statistical adjustments may be required in the final impact analyses (Wilson et al. 2024).

Demographic Characteristics

For demographic characteristics of the young adults in our sample, we tested whether randomization created groups that were statistically equivalent in terms of young adults' race/ethnicity, sex, and age at randomization (table 8). Age at randomization was the only area of statistical nonequivalence with the treatment group about two months younger than the control group at randomization ($p = 0.04$). Both race/ethnicity and age at randomization had effect sizes that fell within the range that may require statistical adjustments in the final impact models per the Clearinghouse.

TABLE 8

Baseline Equivalence Tests of Sample Demographic Characteristics

	Control group *N*	Control group mean (*SD*)/%	Treatment group *N*	Treatment group mean (*SD*)/%	Group differences effect sizes[a]	*p*-value[b]
Race/ethnicity					0.08	0.60
Black, not Hispanic	115	45%	152	43%	--	--
White, not Hispanic	46	18%	79	22%	--	--
Other race, not Hispanic	12	5%	14	4%	--	--
Hispanic, any race	84	33%	109	31%	--	--
Age at randomization[c]	277	19.5	384	19.4	0.16	0.04
Sex					0.0	0.97
Female	155	61%	213	61%	--	--
Male	101	40%	138	39%	--	--

Source: New Jersey Department of Children and Families administrative data.

Note: Data for race/ethnicity and sex exclude 49 young adults who declined consent to access their administrative data and 1 young adult who declined to share their race/ethnicity in the administrative data.

[a] The effect size of group differences uses Cohen's d.

[b] Chi-squares is used for equivalence on race/ethnicity and sex; a *t*-test is used to test for equivalence of age at randomization.

[c] The standard deviation for age was 0.88 for the control group and 0.90 for the treatment group.

Child Welfare History

We used DCF administrative data to test whether randomization created groups that were statistically equivalent in terms of the young adults' removal and placement experiences before randomization. The treatment and control groups were statistically equivalent on all measures of child welfare history (table 9). Most of the measures have effect sizes that fall within the Clearinghouse's adjustment range. The only measures that have equivalent effect sizes are age at first removal, total number of removals, total months in congregate care during the most recent removal, and discharge reason for the most recent removal.

TABLE 9

Baseline Equivalence Tests of Sample Child Welfare Histories

	Control group *N*	Control group mean (*SD*)/%	Treatment group *N*	Treatment group mean (*SD*)/%	Group differences effect size[a]	*p*-value[b]
Lifetime experience						
Age at first removal	248	10.7 (6.2)	334	10.7 (6.1)	0.01	0.93
Total number of removals	257	1.7 (1.0)	355	1.7 (1.1)	0.06	0.46
Never removed	<10	4%	21	6%	-0.11	0.17
Total months in care	257	44.6 (34.7)	355	47.6 (36.9)	-0.08	0.31
Experienced TPR	19	7%	32	9%	-0.06	0.47
Most recent removal[c]						
Age at last removal	248	15.4 (3.5)	334	14.9 (3.4)	0.14	0.09
Months between most recent removal start date and randomization date	248	49 (41.7)	334	53.7 (41.6)	-0.11	0.18
Total months in congregate care	248	4.2 (14.8)	334	4.1 (9.9)	0.01	0.89
Total months in foster home	248	19 (23.5)	334	21.3 (27.2)	-0.09	0.28
Total months in kinship care	248	5.4 (11.5)	334	6.7 (12.1)	-0.11	0.18
Total number of placements	256	3.6 (3.6)	351	4.0 (4.4)	-0.11	0.17
Discharge reason					-0.01	0.84
Reunification	24	11%	26	9%	--	--
Adoption, guardianship, or other permanent home	54	25%	82	28%	--	--

	Control group *N*	Control group mean (*SD*)/%	Treatment group *N*	Treatment group mean (*SD*)/%	Group differences effect size[a]	*p*-value[b]
Aged out	131	60%	168	58%	--	--
Runaway	<10	1%	<10	1%	--	--
Other	<10	3%	<10	3%		

Source: New Jersey Department of Children and Families administrative data.

Note: Data exclude 49 young adults who declined consent to access their administrative data.

TPR = termination of parental rights.

[a] The effect size of group differences uses Cohen's *d*.

[b] Chi-squares was used for equivalence on race/ethnicity and sex; a *t*-test was used to test for equivalence of age at randomization.

[c] Data on placement types include time in placements after age 18 up to randomization date.

For Young Adults Randomized to the Treatment Group, What Was the Rate of Enrollment in LifeSet?

As of February 2024 (nearly a year since randomization concluded), 68 percent of young adults in the treatment group had enrolled in LifeSet (240 out of 355 young adults), with 10 percent still receiving LifeSet services (37 out of 355). Enrollment data show that five young adults had a referral implementing organization that was different from their randomization organization because they moved between regions.[14] We present analyses using the implementing organization that young adults were either referred to or first enrolled with (if different) throughout this section.

Enrollment rates varied by implementing organization (table 10). Region C had the highest enrollment rate at 74 percent of young adults referred while Region A had the lowest enrollment rate at 61 percent. However, a chi-square test found no significant differences across implementing organizations in LifeSet enrollment rates.

[14] Young adults in the treatment group were referred by DCF's OAS to the implementing organization to which they were assigned at the time of randomization, based on their residence at time of screening. However, if young adults moved to another organization's catchment area between screening and referral, then DCF transferred the referral to the appropriate organization.

TABLE 10

LifeSet Enrollment Rates by Implementing Organization

Organization	Enrolled *N*	Enrolled %	Referred but not enrolled *N*	Referred but not enrolled %	Total *N*	Total %
Region A	53	61%	34	39%	87	100%
Region B	71	68%	34	32%	105	100%
Region C	67	74%	24	26%	91	100%
Region D	49	68%	23	32%	72	100%
Total	240	68%	115	32%	355	100%

Source: LifeSet enrollment data from GuideTree.
Note: Data exclude 29 treatment group participants who declined consent to access their administrative data.

The mean time from randomization to enrollment was 31 days while the median was 13 days (table 11). This suggests that most young adults who enrolled did so fairly soon after being referred, but a few waited quite a long time to enroll. There was some variation among implementing organizations in time from randomization to enrollment. Three organizations had median time to enrollment of 12 or 13 days. Region D was the outlier with a median time of 22 days, suggesting this region had fewer young adults enroll very quickly than the other regions; however their mean time to enrollment was similar to other regions. Region C had the lowest mean days to enrollment at 26 while the other implementing organizations had mean times of 32 and 34 days.

We used a Kruskal–Wallis (nonparametric) test to compare the effect of the implementing organization on the median time from randomization to enrollment. The test found a significant difference in median time across organizations (p <.005). Post-hoc comparisons using Dunn's test with a Bonferroni adjustment indicated that the median time of Region D was significantly higher than that of Region A (p < .05), Region B (p < .001), and Region C (p < .05).

TABLE 11

Time between Randomization and Enrollment in LifeSet

Organization	*N*	Mean	Median	Std. Dev.
Region A	53	32.22	13	48.30
Region B	71	34.31	12	87.94
Region C	67	25.51	13	54.14
Region D	49	32.16	22	46.40
Total	240	30.95	13	63.46

Source: LifeSet enrollment data from GuideTree.
Note: Data exclude 29 treatment group participants who declined consent to access their administrative data.

Most young adults enrolled in LifeSet only once; however, 9 percent (n = 21) had more than one enrollment date with one young adult enrolling three times. There are two main reasons why young adults may have multiple LifeSet enrollments. First, they were reassigned to a different implementing organization if they moved outside of their current organization's catchment area. This may have been the case for the 13 young adults who received LifeSet from two implementing organizations. Young adults who changed organizations due to moving may have experienced a gap in service delivery as they had to wait for a program slot to become available with their new implementing organization. However, young adults who were currently enrolled in LifeSet were prioritized for enrollment at another organization if they moved. Two of the 13 young adults who received LifeSet from multiple implementing organizations had a service gap of more than one week when they switched organizations. Second, the LifeSet program allows young adults to stop and resume the program as part of its philosophy of being youth driven. Young adults can choose to formally request a discharge, though LifeSet will also discharge a young adult who has not been in contact with the program for more than 30 days. In New Jersey, young adults who were discharged were allowed to request to reenroll in LifeSet within 12 months of when they first enrolled. There were nine young adults who enrolled in LifeSet twice but with the same implementing organization both times, indicating they may have exited and then reenrolled.

For Young Adults Randomized to the Treatment Group, What Characteristics Distinguish Those Who Enrolled in LifeSet from Those Who Did Not?

We present demographic characteristics and child welfare histories of young adults in the treatment group who enrolled in LifeSet compared with those who did not. Data on young adults' sex and race/ethnicity were drawn from DCF administrative data, and data on young adults' gender identity were drawn from the baseline young adult survey. Understanding differences in characteristics of enrollees and nonenrollees can be useful both to estimate needed program capacity and inform program improvements. For instance, if older young adults are more likely to enroll than those who are younger, program managers can use administrative data on young adults' birth dates to estimate how many program slots may be needed to meet demand. They may also develop and test program enhancements aimed at increasing younger people's enrollment rate.

Sex and Gender Identity

Enrollment rates were the same for both males and females (table 12). For those who completed the survey and responded to the gender identity question (*n* = 206), enrollments were the same for both men and women (76 percent) (table 13).

TABLE 12

Enrollment Rates by Sex

Sex	Enrolled *N*	Enrolled %	Not enrolled *N*	Not enrolled %	Total *N*	Total %
Male	95	68%	45	32%	140	100%
Female	145	67%	70	33%	215	100%
Total	240	68%	115	32%	355	100%

Source: LifeSet enrollment data from GuideTree and administrative data from DCF.
Note: Data exclude 29 treatment group participants who declined consent to access their administrative data.

TABLE 13

Enrollment Rates by Gender Identity

Gender identity	Enrolled *N*	Enrolled %	Not enrolled *N*	Not enrolled %	Total *N*	Total %
Man	58	76%	18	24%	76	100%
Woman	94	76%	29	24%	123	100%
Other Gender	4	67%	2	33%	6	100%
Total	156	76%	49	24%	205	100%

Source: LifeSet enrollment data from GuideTree and baseline young adult survey.
Note: Data exclude 145 treatment group young adults who did not respond to the baseline young adult survey or who declined consent to access their administrative data and 1 young adult who responded "Refused/Don't Know" to the gender identity question in the baseline young adult survey.

Race and Ethnicity

Enrollment rates were similar for non-Hispanic Black young people and Hispanic young people (70 percent and 68 percent, respectively; table 14). Non-Hispanic White young people had the lowest enrollment rate (62 percent); however, results of a chi-square test found no significant differences in enrollment based on participants' race and ethnicity.

TABLE 14

Enrollment Rates by Race and Ethnicity

Race/ethnicity	Enrolled *N*	Enrolled %	Not enrolled *N*	Not enrolled %	Total *N*	Total %
White, not Hispanic	49	62%	30	38%	79	100%
Black or African American, not Hispanic	107	70%	45	30%	152	100%
Hispanic/Latino, any race	74	68%	35	32%	109	100%
Other race, not Hispanic	9	64%	5	36%	14	100%
Total	239	68%	115	32%	354	100%

Source: LifeSet enrollment data from GuideTree and administrative data from DCF.

Note: Data exclude 29 treatment group participants who declined consent to access their administrative data and 1 young adult whose race/ethnicity was missing in the administrative data.

Age at Randomization

Most young adults in the treatment sample were age 18 to 19 at randomization (table 15). Enrollment rates were similar for those randomized at age 18 or 19 (65 percent versus 67 percent), with a small increase for those age 20 at randomization. The mean age at randomization for those who enrolled in LifeSet was 19.4 years, and the mean age for those who chose not to enroll was 19.2 years. Results of a *t*-test found a statistically significant difference in the mean age at randomization between young adults who enrolled in LifeSet and those who did not enroll ($p < .05$), though this difference is not likely substantively meaningful.

TABLE 15

Enrollment Rates by Age at Randomization

Age at randomization	Enrolled *N*	Enrolled %	Not enrolled *N*	Not enrolled %	Total *N*	Total %
17	3	50%	3	50%	6	100%
18	90	65%	49	35%	139	100%
19	82	67%	41	33%	123	100%
20	58	73%	21	27%	79	100%
21	7	87%	1	13%	8	100%
Total	240	68%	115	32%	355	100%

Source: LifeSet enrollment data from GuideTree.

Note: Data exclude 29 treatment group participants who declined consent to access their administrative data.

Child Welfare History

Understanding whether young adults with certain child welfare histories are more likely to enroll in LifeSet can aid both in estimating program demand and targeting program improvements. Overall, the experiences of young adults who enrolled in LifeSet were similar to those who opted not to enroll. However, young adults who enrolled in LifeSet spent significantly less time placed with kin during their most recent removal than those who did not enroll (table 16). Enrolled young adults spent an average of 5.5 months placed with kin compared with an average of 9.1 months for nonenrolled young adults. It may be that young adults who spend more time placed with kin have stronger support systems and thus feel less of a need for the type of support that LifeSet provides. There were no other significant differences in child welfare histories between enrollees and nonenrollees.

TABLE 16

Enrollment Rates by Child Welfare History

	Enrolled *N*	Enrolled mean (*SD*)/%	Not enrolled *N*	Not enrolled mean (*SD*)/%	Total *N*	Total mean (*SD*)/%
Lifetime experience						
Age at first removal	224	10.6 (6.1)	110	10.9 (6.1)	334	10.7 (6.1)
Total number of removals	240	1.7 (1.2)	115	1.6 (0.9)	355	1.7 (1.1)
Never removed	16	7%	5	4%	21	6%
Total months in care	240	48.3 (37.7)	115	46.1 (35.4)	355	47.6 (36.9)
Experienced TPR	25	10%	7	6%	32	9%
Most recent removal						
Age at last removal	224	14.9 (3.7)	110	14.9 (2.8)	334	14.9 (3.4)
Months between most recent removal start date and randomization date	224	54.9 (45.0)	110	51.3 (33.7)	334	53.7 (41.6)
Total months in congregate care	224	4.6 (10.2)	110	3 (9.4)	334	4.1 (9.9)
Total months in foster home	224	21.8 (28.3)	110	20.4 (24.8)	334	21.3 (27.2)

	Enrolled *N*	Enrolled mean (*SD*)/%	Not enrolled *N*	Not enrolled mean (*SD*)/%	Total *N*	Total mean (*SD*)/%
Total months in kinship care	224	5.5 (10.9)	110	9.1 (13.9)	334	6.7** (12.1)
Total number of placements	240	4.1 (4.5)	115	3.9 (4.4)	355	4.0 (4.4)
Discharge reason						
Reunification	21	11%	5	6%	26	9%
Adoption, guardianship, or other permanent home	55	28%	27	30%	82	28%
Aged out	112	57%	56	62%	168	58%
Runaway	2	1%	2	2%	4	1%
Other	8	4%	1	1%	9	3%

Source: New Jersey Department of Children and Families administrative data.
Notes: Data exclude 49 young people who declined consent to access their administrative data. Chi-square was used to test for significant differences for categorical variables; a *t*-test was used to test for significant differences for continuous variables.
[a] Calculated as months between most recent removal start date and date of randomization, if 17 when randomized.
** $p = 0.01$
TPR = termination of parental rights.

Understanding LifeSet Implementation

We present our findings for research questions d–f in table 1 related to how LifeSet differs from usual services, how young adults are recruited and enrolled in LifeSet, and the fidelity of LifeSet's implementation in New Jersey.

How Does LifeSet Differ from Usual Services?

We used data gathered from interviews and focus groups with young adults enrolled in LifeSet as well as staff from the LifeSet implementing organizations and DCF to explore how LifeSet differs from usual services. Some respondents stated that they saw similarities between the goals of LifeSet and the usual services offered to transition-age young people in New Jersey. What they felt was different was LifeSet's approach to working with young adults—for example, the frequency with which LifeSet specialists met with them and the broad approach that gives young adults flexibility around what goals they choose to

work on. LifeSet's scope and flexibility, program goals, communication with young adults, and well-defined model were perceived by those we spoke with as key features that distinguish it from services as usual.

Implementing organization and DCF staff talked about LifeSet's scope and flexibility relative to other services and programs. Most other programs focus on one or a few domains of independent living whereas LifeSet can support young adults in many domains. For example, multiple interviewees brought up the Pathways to Academic and Career Exploration to Success (PACES) program, which focuses on education and career training and contrasted this "specific focus" with LifeSet's flexibility to work with young adults on any of their priorities. Implementing organization and DCF interviewees also reflected on the breadth of what the LifeSet program offers to support young adults, mentioning examples such as a specialist driving a young adult to the emergency room in the middle of the night and another specialist supporting a young adult by attending a medical appointment together. One LifeSet specialist shared,

> And I think that's one of the best things about our program is that like, "Hey. Maybe you have a support, and they're not stepping in, or you don't even have the support, but you need help with this?" We're kind of, like, that giant umbrella that will cater to any goal you really need help with. Or at least, you know, we'll try to learn it along with you to accomplish that goal.

Implementing organization and DCF staff interviewees also brought up how the goals of LifeSet may be similar to or different from other programs. One staff interviewee talked about how a different program focused on the outcome of psychosocial well-being and compared this goal with LifeSet's goals, which they saw as "looking at the promotion of tangible skills…they seem to be smart goals." Another staff interviewee felt that LifeSet worked with young people in a different way, describing other programs as more about "teaching things, but not necessarily doing it alongside the young adults." They shared that LifeSet focuses more on the "how" of accomplishing certain goals and building young adults' capacity to do things for themselves in the future. They offered the example of building young adults' capacity around how to get a job rather than simply checking a box that the young adult got a job.

LifeSet's level of communication and follow-up with young adults was perceived by both young adult and staff respondents as a distinguishing factor from other services. Respondents talked about how other programs may miss weeks of communication or do not always pick up the phone or answer their emails. LifeSet requires specialists to meet young adults in-person and check in with greater frequency—at least weekly. This contrasts with many other programs respondents mentioned, which meet with young adults monthly, or the PACES program, which meets with them every other week.

One DCF staff interviewee noted that the greater frequency of interactions between LifeSet specialists and young adults results in a stronger relationship than is found in other programs. They provided an example of a young adult who was failing in school and whose other service provider "gave

up on him." The LifeSet specialist stuck with him and "wouldn't take no for an answer," and now this young adult has their GED and a job. This anecdote aligns with how young adults described LifeSet specialists as committed to helping them achieve their goals.

For the young adults we spoke with, LifeSet was perceived as being more attentive to their goals and wants than other available programs. One young adult contrasted their experiences with LifeSet to other programs, stating, "My other workers, it's always what they want to do, not me." Young adults we spoke with often described LifeSet as a program that "listens to them" in terms of case planning and goal setting. Young adults reflected on how their LifeSet specialists are caring, using words and phrases such as, "down-to-earth" and "attentive" to describe their specialists.

How Are Eligible Young Adults Identified, Recruited, and Enrolled in the LifeSet Program?

Our interviews and focus groups with implementing organization staff surfaced five themes related to the identification, recruitment, and enrollment of young adults in LifeSet (see appendix D for details on the methodology used to code and derive themes). We discuss each theme below.

DCF's Role in Identification and Recruitment

As noted in the referral and randomization strategy section, DCF identified which young adults were eligible for LifeSet through a two-step screening process. After receiving the randomization results, DCF sent referrals for young adults in the treatment group to a LifeSet implementing organization, often by the next business day, and notified the young adult's CP&P caseworker of the referral. Referrals for services as usual were made by individual CP&P caseworkers for services either requested by a young adult or in response to their need. DCF interviewees stated that this was the first time the OAS had instituted a centralized referral process for a service. While the evaluation was the primary reason a centralized process was used for LifeSet, interviewees stated that the experience had led them to consider applying it to other services.

Referrals Assigned Based on Specialist's Caseload

LifeSet supervisors stated they tried to take into account factors such as the young adult's demographics (e.g., gender, Spanish speaking) and location relative to other young adults on specialists'

caseloads when assigning referrals. However, they stated that referrals were often assigned based on which specialist had capacity at the moment. The assigned specialist typically conducted the initial outreach to referred young adults to provide them with information about LifeSet and schedule a meeting to discuss enrolling. Sometimes the supervisor would conduct outreach if a specialist was on leave or if the supervisor was carrying a caseload because of vacancies on the team.

Contact with CP&P Caseworkers Was at the Specialists' Discretion

Some specialists stated they always tried to contact a young adult's CP&P caseworker to get more background information such as their child welfare history, living situation, other services, and areas of need. They noted that some CP&P caseworkers shared little to no information about the young adults, while others would provide information on a young adult's history of engagement and their goals. This information could be useful in encouraging young people to enroll by highlighting a specific need or interest that LifeSet could support. However, other specialists stated they preferred to have a "blank slate" of sorts when entering conversations with young adults. Though they may have information from the caseworker or from the referral form, specialists expressed that they try to be "open-minded" or take the information with a "grain of salt" so as not to form snap judgements about young adults.

Intake Assessment Is Comprehensive but Can Feel Intrusive to Specialists

The LifeSet enrollment process includes a psychosocial assessment that covers young adults' background information, risk and safety behaviors, physical and mental health, education and employment, housing, and goals. The assessment process is often done over two to three meetings with the young adult. A couple of specialists stated that they will do all of the assessments in a 90-minute session if they have consent, framing it as getting all the paperwork done so that sessions can focus on what the young adults want.

Specialists stated in April 2023, the month after randomization ended, that the assessments had recently changed. This change would have impacted young adults who were referred during the last months of randomization. Some specialists expressed that the new questions seemed more intrusive and duplicative of information young adults may already be sharing with other programs, which could be disengaging. Specialists mentioned the new assessment questions about sexual activity and intimate relationships as feeling particularly intrusive, especially if the young person was 17 and still living with a foster parent. An interviewee shared that they try to change the language of some of the more personal questions a bit so that young people are not put off by the questions. Specialists also stated that some of

the new assessment items ask for the same information using different phrasing. They acknowledged this is intended to get "the true answer" but stated that young adults are able to pick up on it.

Youth Villages interviewees confirmed that the assessments had undergone a program-wide change. Training for the New Jersey implementing organizations began in February 2023, and the new assessments were implemented by April. Interviewees stated the changes were made to catch risk behaviors before they potentially became major safety concerns, such as gun violence and street group involvement. They noted that the revised assessments underwent review by people with lived experience in foster care for cultural sensitivity and placement of any trigger warnings.

Specialists Used Multiple Methods to Encourage Youth Enrollment

Specialists discussed using a variety of outreach and communication methods to inform young adults about the LifeSet program and encourage them to enroll. In focus groups, specialists talked about how they may reach out to young adults via phone call or text (which could be more effective) with some facts about the program and how they were connected with the young adult through the CP&P caseworker. Interviewees talked about having an "elevator pitch"—informational materials such as brochures, testimonials from formerly enrolled young adults, or links to the LifeSet website—to inform young adults about the LifeSet program. One interviewee shared that after this initial conversation, they tried to schedule a follow-up where they "bring [the young adult] something they enjoy," like a coffee or food, and "meet them in the community wherever it is that they're comfortable and go from there."

If young adults were not interested in the LifeSet program at the time of referral, LifeSet staff shared that they may follow up with the young people in a couple of weeks or months to see if they feel ready to engage with the program at that point. They noted that young adults may be busy with school, jobs, or other commitments taking up their time and may not have time to engage with the LifeSet program at their referral time.

Specialists had mixed feelings about doing pop-ups. Specialists and supervisors mentioned that the LifeSet licensed program experts encouraged them to conduct unannounced visits to young adults' residences (referred to as "pop-ups") to engage referred young people who had not responded to calls or texts to enroll. Specialists we spoke with expressed mixed feelings about doing pop-ups. One interviewee shared that they tried pop-ups, but they "have not found that to be a wonderful tool" to engage reluctant young adults. Two specialists mentioned potential safety concerns for staff around doing pop-ups, saying that such pop-ups can be "stressful" depending on the relative safety of the area. Another specialist shared that staff comfort levels vary with doing pop-ups, stating that "there

were just some things getting in the way, maybe some implicit biases, people kind of placing their own discomfort for what they would be comfortable with on the youth." Some felt the pressure to conduct pop-ups, especially multiple times after young people had declined LifeSet, was at odds with the program's philosophy of being youth driven. They noted that some young adults refer to it as "harassment" and feel like it's a "turnoff to some [young adults] at the beginning."

A common tactic was focusing on how LifeSet is unique. Program staff stated that young adults may initially perceive LifeSet as just another program and thus not see much value in participating. One strategy used to engage young adults was to focus on how LifeSet is unique and not a duplication of other services. They shared that "sometimes it's getting to that point and not having them hang up on us." A CP&P caseworker shared that for young adults who are hesitant to have another program "all up in [their] business," they talk about the benefits of LifeSet, such as how participating in a voluntary program would "look good" to a judge. Some specialists and CP&P caseworkers also try to frame LifeSet as a support, because calling it a program can have negative connotations.

[T]he word "program" is like a curse. I've noticed that when I tell some of these adolescents about what we identify as programs, but I identify them as supports and providers, it makes a difference.
—CP&P caseworker

A specialist shared that they also try to explain the program's benefits and empathize with the young adults to "boost" engagement—such as complaining about the assessment together. A couple of specialists shared that they encourage the young people to try enrolling in the program for a few months, emphasizing they can quit if they do not like it. They stated that sometimes the young adults find they enjoy LifeSet and stay enrolled.

Is LifeSet Being Delivered as Youth Villages Intended, or Are Modifications Being Made for the New Jersey Context?

Youth Villages has conducted four certification reviews of each implementing organization in New Jersey: a six-month baseline certification was completed in spring 2021, and annual certifications were completed in fall 2021, 2022, and 2023. For all four certifications, the New Jersey organizations met the minimum thresholds with overall scores ranging from 84 percent to 95 percent. Clinical subscale scores ranged from 84 percent to 95 percent and operations subscale scores ranged from 84 percent to 94 percent (see appendix D for additional details).

All four implementing organizations had to complete performance improvement plans after each review. The individual items on the plans varied across organizations and over time. Areas for improvement that were on several New Jersey implementing organizations' plans included the following:

- clinical subscale items related to
  - quality of assessments,
  - quality of staff development plans,
  - safety-related measures in service plans and group supervision notes,
  - consultation attendance, and
  - field visits and group supervision feedback included in the development plan;
- operations subscale items related to
  - average daily census,
  - number of required sessions held, and
  - full staffing structure.

Interview data also suggest that LifeSet was implemented with fidelity in New Jersey. Descriptions of the program provided by the implementing organizations, LifeSet staff, and licensed program experts during interviews align with core aspects of the program. These include the LifeSet team structure, individual and group supervision, clinical consultation, use of GuideTree assessments and interventions, weekly meetings with young adults, and working toward young adults' monthly goals. Young adults in the treatment group in LifeSet also described the program in a way that confirms fidelity, such as weekly meetings with their specialist at home or in the community and setting and working toward their personally defined goals.

The use of virtual sessions is one area in which implementation in New Jersey did not align with the original LifeSet model. Youth Villages allowed virtual sessions during the COVID-19 pandemic. Pandemic restrictions on in-person interactions required specialists to conduct weekly sessions with young adults virtually, often through Zoom or FaceTime, but also sometimes by phone call, in 2021. Virtual sessions remained an option through 2022 if the specialist or young adult was ill or had a COVID-19 exposure. By 2023, Youth Villages had reinstated the requirement that only in-person sessions would count toward KPIs and fidelity. However, specialists stated in focus groups that young adults would ask to meet virtually if it fit better with their school or work schedules. Specialists stated they sometimes acquiesced to these requests, viewing a virtual session as better than no session.

Finally, specialists and supervisors mentioned in focus groups that there were a few instances where a referred young adult should have been screened out as ineligible. This was usually related to possible gang involvement, which some specialists acknowledged that the CP&P caseworker may not have been aware of. After internal discussions and consultation with licensed program experts, LifeSet staff interviewees stated they continued working with these young adults but took additional safety precautions (e.g., meeting in a neutral location or only during daylight).

Discussion

Key Findings

Overall, the randomization process resulted in groups that were statistically equivalent on most demographic characteristics and measures of child welfare history. Only age at randomization was statistically nonequivalent with the young adults in treatment group about two months younger than those in the control group. However, the groups were not equivalent when using the Title VI-E Prevention Services Clearinghouse standards based on effect size. The Clearinghouse considers effect sizes of less than 0.05 as equivalent, while effect sizes of 0.05 to 0.25 require statistical adjustment to meet baseline equivalence. The effect sizes of 10 out of 15 baseline equivalence tests fell within the Clearinghouse's adjustment range of 0.05 to 0.25. Thus, future impact analyses will need to include these measures as covariates to meet the Clearinghouse standards.

Our study sample in New Jersey was different from the study sample in the previous RCT of LifeSet (Courtney, Valentine, and Skemer 2019) in a few notable ways. Our study sample is older (31 percent >20-years-old versus 9 percent), more female (61 percent versus 48 percent), and composed of more young adults of color (78 percent versus 49 percent) than the previous study sample, which was conducted in Tennessee. Nearly all (95 percent) young adults in our sample had been in foster care at some point compared with less than two-thirds of the Tennessee sample. These differences reflect the differences in how the samples were identified and recruited for the respective studies. Most notably, the Tennessee study enrolled young adults from both the child welfare and juvenile justice systems, whereas New Jersey enrolled young adults involved with DCF through either in-home services or out-of-home placement. In the Tennessee study, Youth Villages LifeSet received a list of 17-year-olds in state custody, targeted outreach to those who had already aged out, and screened young adults for eligibility. Only young adults who were both eligible for and interested in LifeSet were enrolled in the Tennessee study. By contrast, young adults in our study were identified as eligible solely by DCF and then randomized into the study prior to learning about LifeSet. The two states also have different extended care policies, that may explain some of the sample differences. At the time of the previous study, young adults in Tennessee had to be in school or have a medical condition that prevented school attendance to be in extended foster care. This is in contrast to New Jersey, which allows young adults to receive services after age 18 so long as they participate in a minimum of 20 hours of productive time per

week (e.g., education, employment, volunteering, mental health treatment).[15] The less strict criteria in New Jersey may result in more young people remaining in contact with the state agency than in Tennessee.

Sixty-eight percent of young adults in the treatment group enrolled in LifeSet. This is notably lower than the 97 percent of the treatment group that enrolled in the Tennessee LifeSet study (Courtney, Valentine, and Skemer 2019). Participants in the Tennessee study had to agree to LifeSet services *before randomization*, whereas young adults in our study were told about LifeSet only *after randomization*, which likely explains the large differences in program enrollment. Our study's enrollment rate is slightly lower than in an RCT of Life Skills Training in Los Angeles, which also randomized young adults before program referral and had a treatment uptake rate of 76 percent, though that program was very different from LifeSet's model and required less commitment from young adults (Courtney et al. 2008).

Most of the differences between young adults in the treatment group who did or did not enroll in LifeSet were not statistically significant. The only significant difference was that nonenrollees spent more time in kinship placements on average than enrollees. This information could inform LifeSet improvement efforts. For instance, the program may want to test out different methods for encouraging young adults placed primarily with kin to enroll. Alternatively, the program could use this information to develop approaches that are aligned with the needs of young adults who are most likely to enroll.

Specialists implemented a variety of methods and strategies to engage young adults in LifeSet. The most common strategy mentioned was emphasizing the youth-driven nature of the program, particularly the flexibility for young people to work on their individual goals. Although specialists expressed some frustration with the program's use of pop-ups (i.e., unannounced visits), they also acknowledged that it often took multiple outreach attempts to engage young adults. Some specialists appeared to use the strategy of "just try it for a month or two" to overcome young adults' reluctance to enroll. What came through clearly in the LifeSet supervisor and specialist focus groups was the attitude of "doing whatever it takes" to connect with young adults. Indeed, one young man stated during his interview that he only agreed to enroll after learning that his specialist was also into jujitsu. Another common engagement tactic was to bring young adults food or take them out to eat.

We also heard consistently across all respondent types that LifeSet provides a level of support that is not typical of other services available to young adults in DCF services. Young adults in the treatment

[15] A description of what qualifies as "productive time" can be found in DCF policy CPP-X-A-1-10.10 in the "New Jersey Department of Children and Families Policy Manual," February 4, 2019, https://dcfpolicy.nj.gov/api/policy/download/CPP-X-A-1-10.10.pdf.

group in particular noted that LifeSet specialists are accessible and supportive in ways that staff in other programs are not. Nearly all the young adults we spoke with used only positive phrases to describe their specialist. In particular, young people noted that their specialists often stuck with them and followed through on their commitments—something they said they did not get from staff in other programs. Staff who had worked in other adolescent programs also agreed that LifeSet's youth-driven model distinguished it from services as usual.

Limitations

This study has two key limitations. The first major limitation is the high rate of baseline survey nonresponse, which affects our ability to determine whether the treatment and control groups had similar characteristics at baseline. The second major limitation is the low enrollment rate in LifeSet among those assigned to the treatment group, which impacts the conclusions we can draw from our future outcome analyses.

A primary limitation of our study is the high rate of baseline survey nonresponse. Other studies of transition-age young people that used interviewer-administered surveys often achieved baseline response rates in the 80 percent to 90 percent range (Courtney et al. 2008; 2014; Courtney, Valentine, and Skemer 2019), much higher than our 60 percent response rate. Pandemic restrictions on in-person data collection likely contributed to our low survey response rate. Like most young adults, our study sample relies on cell phones. However, young adults in extended foster care are known to have inconsistent cell phone access (Courtney et al. 2020). Additionally, fewer people in general are likely to answer a cell phone call from an unknown number due to increased spam and marketing calls.[16] Our response rates suggest that phone surveys are not the best method for recruiting young adults in extended foster care to participate in evaluations.

Our low baseline survey response rate may limit our assessment of baseline equivalence to demographic and child welfare history characteristics rather than on direct pretests of outcomes in future impact analyses. Due to the low response rate, we cannot be certain that our treatment and control groups were similar at baseline on the outcomes of interest that are only available on the survey (e.g., education level, employment, housing stability, well-being). However, our analysis of survey responders versus

[16] Colleen McClain, "Most Americans Don't Answer Cellphone Calls from Unknown Numbers," *Pew Research Center* (blog), December 14, 2020, https://www.pewresearch.org/short-reads/2020/12/14/most-americans-dont-answer-cellphone-calls-from-unknown-numbers/.

nonresponders found only two areas of significant differences, suggesting there was little systematic bias in who responded. This provides more confidence that our baseline equivalence tests will not be biased.

The enrollment rate of young adults in the treatment group in LifeSet may limit our ability to find impacts in the future. Because we will use intent-to-treat analysis for the future impact evaluation, the large share of young adults in the treatment group who never received the treatment could make it appear that LifeSet does not have an impact even if it actually does. Our intent-to-treat analysis will compare young adults who were not assigned to receive the treatment with those who were assigned to receive the treatment—not those who actually *received* the treatment. This could cause our analyses to incorrectly show that LifeSet is no better than services as usual, even if LifeSet does have an impact in reality. In addition to the intent-to-treat analysis, we may consider conducting a treatment-on-the-treated analysis to estimate the treatment effect of LifeSet. However, any treatment-on-the-treated analysis should be interpreted with caution because the young adults who choose to enroll in LifeSet may have characteristics that also make them more likely to have positive long-term outcomes independent of their enrollment in LifeSet, which could lead us to incorrectly find that LifeSet had an impact.

A key difference between our current study and the prior RCT in Tennessee was the timing of referral relative to randomization. In the prior RCT, participants referred to LifeSet had to both want the service and agree to randomization to have a chance at receiving it (Courtney, Valentine, and Skemer 2019). Thus, they had to express interest in LifeSet before randomization. The current study by contrast randomized the *offer* of LifeSet: only young adults randomized to the treatment group were referred and given the offer of receiving LifeSet services. One advantage of our study's method is the ability to know more accurately how many eligible young adults would enroll in LifeSet if all were given the opportunity to do so. This information is useful to program administrators when estimating how many service slots will be needed to meet demand.

Next Steps

Urban is conducting a follow-up survey through grant funding from Youth Villages. The survey will be administered at approximately 24-months postrandomization to all randomized young adults, regardless of whether they responded to the baseline survey. We may also receive administrative data from additional sources to assess outcomes such as incarceration, public benefits receipt, education, and employment. We will conduct our impact analyses in accordance with our preregistered analytic plan (Pergamit and Courtney 2023). We expect to publish the final impact study report in late 2026.

Appendix A. Baseline Young Adult Survey Item Citations

Survey section	Source	Citation
Living arrangements	California Youth Transitions to Adulthood Study (CalYOUTH)	Courtney, Mark E., Pajarita Charles, Nathanael J. Okpych, Laura Napolitano, and Katherine Halsted. 2014. *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Foster Youth at Age 17*. Chicago: Chapin Hall at the University of Chicago.
	Midwest Study of the Adult Functioning of Former Foster Youth (MWS)	Courtney, Mark, Jennifer Hook, Adam Brown, Colleen Cary, Kara Love, Vanessa Vorhies, JoAnn Lee, Melissa Raap, Gretchen Cusick, Thomas Keller, Judy Havlicek, Alfred Perez, Sherri Terao, and Noel Bost. 2011. "Midwest Evaluation of the Adult Functioning of Former Foster Youth." Chicago: Chapin Hall at the University of Chicago.
Social support	Social Support Network Questionnaire (SSNQ)	Gee, Christina B., and Jean E. Rhodes. 2007. "A Social Support and Social Strain Measure for Minority Adolescent Mothers: A Confirmatory Factor Analytic Study." *Child: Care, Health, and Development* 34 (1): 87–97. https://doi.org/10.1111/j.1365-2214.2007.00754.x.
Fertility	Midwest Study of the Adult Functioning of Former Foster Youth (MWS)	Courtney, Mark, Jennifer Hook, Adam Brown, Colleen Cary, Kara Love, Vanessa Vorhies, JoAnn Lee, Melissa Raap, Gretchen Cusick, Thomas Keller, Judy Havlicek, Alfred Perez, Sherri Terao, and Noel Bost. 2011. "Midwest Evaluation of the Adult Functioning of Former Foster Youth." Chicago: Chapin Hall at the University of Chicago.
Education	Midwest Study of the Adult Functioning of Former Foster Youth (MWS)	Courtney, Mark, Jennifer Hook, Adam Brown, Colleen Cary, Kara Love, Vanessa Vorhies, JoAnn Lee, Melissa Raap, Gretchen Cusick, Thomas Keller, Judy Havlicek, Alfred Perez, Sherri Terao, and Noel Bost. 2011. "Midwest Evaluation of the Adult Functioning of Former Foster Youth." Chicago: Chapin Hall at the University of Chicago.
Employment and earnings	National Longitudinal Survey of Youth 1997 (NLSY97)	Bureau of Labor Statistics, US Department of Labor. 2013. National Longitudinal Survey of Youth 1997 cohort, 1997–2011 (rounds 1–15). Columbus, OH: Produced by the National Opinion Research Center, the University of Chicago and distributed by the Center for Human Resource Research, The Ohio State University. Retrieved from https://www.nlsinfo.org/content/cohorts/nlsy97.
Economic hardship	National Longitudinal Study of Adolescent Health (Add Health)	Harris, Kathleen M., Carolyn Tucker Halpern, Eric A. Whitsel, Jon M. Hussey, JoyceTabor, Pamela P. Entzel, and Richard J. Udry. 2009. The National Longitudinal Study of Adolescent Health: Research design. Retrieved from http://www.cpc.unc.edu/projects/addhealth/design.
Mental health services	California Youth Transitions to Adulthood Study (CalYOUTH)	Courtney, Mark E., Pajarita Charles, Nathanael J. Okpych, Laura Napolitano, and Katherine Halsted. 2014. *Findings from the California Youth Transitions to Adulthood Study (CalYOUTH): Conditions of Foster Youth at Age 17*. Chicago: Chapin Hall at the University of Chicago.

Survey section	Source	Citation
Substance abuse	Midwest Study of the Adult Functioning of Former Foster Youth (MWS)	Courtney, Mark, Jennifer Hook, Adam Brown, Colleen Cary, Kara Love, Vanessa Vorhies, JoAnn Lee, Melissa Raap, Gretchen Cusick, Thomas Keller, Judy Havlicek, Alfred Perez, Sherri Terao, and Noel Bost. 2011. "Midwest Evaluation of the Adult Functioning of Former Foster Youth." Chicago: Chapin Hall at the University of Chicago.
Criminal justice involvement	National Longitudinal Survey of Youth 1997 (NLSY97)	Bureau of Labor Statistics, US Department of Labor. 2013. National Longitudinal Survey of Youth 1997 cohort, 1997–2011 (rounds 1–15). Columbus, OH: Produced by the National Opinion Research Center, the University of Chicago and distributed by the Center for Human Resource Research, The Ohio State University. Retrieved from https://www.nlsinfo.org/content/cohorts/nlsy97.
Spouse/partner violence	Midwest Study of the Adult Functioning of Former Foster Youth (MWS)	Courtney, Mark, Jennifer Hook, Adam Brown, Colleen Cary, Kara Love, Vanessa Vorhies, JoAnn Lee, Melissa Raap, Gretchen Cusick, Thomas Keller, Judy Havlicek, Alfred Perez, Sherri Terao, and Noel Bost. 2011. "Midwest Evaluation of the Adult Functioning of Former Foster Youth." Chicago: Chapin Hall at the University of Chicago.
Spouse/partner violence	Conflict Tactic Scale (CTS)	Straus, Murray A., Sherry L. Hamby, Sue Boney-McCoy, David B. Sugarman. 1996. "The Revised Conflict Tactics Scales (CTS2): Development and Preliminary Psychometric Data." *Journal of Family Issues* 17 (2): 283–316.
Youth resiliency	Youth Thrive™	Center for the Study of Social Policy (CSSP). 2020. *Youth ThriveTM Survey User Manual*. Washington, DC: CSSP.
Social-emotional competence	Youth Thrive™	Center for the Study of Social Policy (CSSP). 2020. *Youth ThriveTM Survey User Manual*. Washington, DC: CSSP.

Appendix B. Comparison of DCF Administrative Data with Youth Self-Report Demographics

The baseline survey allowed young adults to self-report their sex assigned at birth, race, and Hispanic ethnicity. The DCF administrative data also contained information on young adults' sex, race, and Hispanic ethnicity. We compared the two sources for young adults who appear in both datasets.

Sex

Sex data were available in both DCF administrative and survey data for 344 young adults (table B.1). Sex in both datasets matched for more than 99 percent of young people. Sex differed between datasets for less than 1 percent of (*n* = 2) young adults.

TABLE B.1

Sex Comparison between DCF Administrative Data and Youth Self-Report

Sex	*N*	%
Matched—male	123	36%
Matched—female	219	64%
Did not match	2	<1%
Total	344	100%

Sources: New Jersey Department of Children and Families administrative data and baseline young adult survey data.
Note: Data for sex exclude 317 young adults who are missing from the data because they did not complete the survey, they declined to consent to access their administrative data, or they did not respond to the sex item in the survey.

Race and Ethnicity

Race and ethnicity data were available in both DCF administrative and survey data for 344 young adults. Exact comparisons between the datasets are not possible due to slight differences in how information was recorded. The survey included a list of six racial options and allowed young people to select all races that applied to them. In contrast, the administrative data reported no more than two races per person. Both sources reported Hispanic ethnicity as a separate yes or no field. For each data source, we combined race and ethnicity into a single mutually exclusive variable following standard

census procedures. Again, information in both datasets matched for most young adults (83 percent). Mismatches were most commonly related to Hispanic ethnicity. Table B.2 provides a breakdown of the data that matched (*n* = 286). Table B.3 provides a breakdown of the data that did not match (*n* = 58).

TABLE B.2

Race/Ethnicity Matches between DCF Administrative Data and Youth Self-Report Survey Data

Race	Matched *N*	Matched %
White, only	54	19%
Black or African American, only	123	43%
Hispanic/Latino	99	35%
Other race, only	10	3%
Total	286	100%

Sources: New Jersey Department of Children and Families administrative data and baseline young adult survey data.
Note: Data for race/ethnicity exclude 317 young adults who are missing data because they declined to consent to access their administrative data, they did not complete the survey, or they did not respond to the race items in the survey.

TABLE B.3

Race/Ethnicity Mismatches between DCF Administrative Data and Youth Self-Report Survey Data

Admin data race	Survey race	*N*	%
White, only	Hispanic/Latino	9	16%
White, only	Other race, only	4	7%
Black or African American, only	Hispanic/Latino	16	28%
Black or African American, only	Other race, only	19	33%
Hispanic/Latino	Black or African American, only	1	2%
Hispanic/Latino	Other race, only	4	7%
Other race, only	Black or African American, only	5	9%
Total		58	100%

Sources: New Jersey Department of Children and Families administrative data and baseline young adult survey data.
Notes: Data for race/ethnicity exclude 317 young adults who are missing data because they declined to consent to access their administrative data, they did not complete the survey, or they did not respond to the race items in the survey.

Appendix C. Sample Demographic Characteristics by Implementing Organization Region

TABLE C.1

Age at Randomization by Implementing Organization Region

Age at randomization	Region A *N*	Region A %	Region B *N*	Region B %	Region C *N*	Region C %	Region D *N*	Region D %
17	10	6%	0	0%	0	0%	0	0%
18	66	41%	93	46%	17	10%	62	46%
19	36	23%	63	31%	72	43%	49	37%
20	46	29%	42	21%	68	41%	23	17%
21	2	1%	3	2%	9	5%	0	0%
Total	160	100%	201	100%	166	100%	134	100%

Source: Urban Institute analysis of randomization data.

TABLE C.2

Race and Ethnicity by Implementing Organization Region

Race/Ethnicity	Region A *N*	Region A %	Region B *N*	Region B %	Region C *N*	Region C %	Region D *N*	Region D %
White, not Hispanic	44	29%	24	13%	24	16%	33	26%
Black or African American, not Hispanic	68	45%	87	47%	60	40%	52	42%
Hispanic/Latino, any race	32	21%	70	38%	59	39%	32	26%
Other race, not Hispanic	7	5%	3	2%	8	5%	8	6%
Total	151	100%	184	100%	151	100%	125	100%

Source: New Jersey Department of Children and Families administrative data.
Note: Data for race/ethnicity exclude 49 young adults who declined consent to access their administrative data and 1 young adult who declined to share their race/ethnicity in the administrative data.

TABLE C.3

Sex by Implementing Organization Region

Sex	Region A *N*	Region A %	Region B *N*	Region B %	Region C *N*	Region C %	Region D *N*	Region D %
Male	60	40%	70	38%	51	34%	60	48%
Female	91	60%	115	62%	100	66%	65	52%
Total	151	100%	185	100%	151	100%	125	100%

Source: New Jersey Department of Children and Families administrative data.
Note: Data for sex exclude 49 young adults who declined consent to access their administrative data.

Appendix D. Detailed Methods

We selected New Jersey for the evaluation after conversations with Youth Villages and DCF determined that more young adults were eligible for LifeSet than could be served with available resources and the state indicated it would support a rigorous evaluation. Implementation of LifeSet in New Jersey consisted of four private local nonprofit organizations who each had one LifeSet team composed of four specialists and a supervisor.

We used administrative data and baseline survey data to answer research questions related to baseline equivalence and treatment group enrollment in LifeSet (a–c in table 1). We used interviews and focus groups to answer research questions related to the implementation of LifeSet and how it differed from services as usual (d–f in table 1). We also used administrative data from Youth Villages to answer question f about whether LifeSet was delivered as intended. Interviews and focus groups were conducted with staff from DCF, Youth Villages, and the implementing organizations, and with young adults randomized to the treatment and control groups.

Youth Villages and DCF identified the outcomes as the primary domains LifeSet was intended to target in New Jersey. The LifeSet logic model identifies additional outcome domains that the program may impact (figure 1). The evaluation included these domains as secondary outcomes of interest: mental health; contact with the criminal justice system; intimate partner violence; and economic well-being. These are secondary outcomes because they are not the primary targets of the program in New Jersey and should not be used to determine programmatic effectiveness.

Target Population Referrals

Referrals to the program began with young adults ages 20 to 21 and then moved to successively younger age groups as slots became available. Young adults referred to the program before August 2021 were not included in the study sample. Before the start of randomization, the estimated target population was 900 age-eligible young adults in the target counties. The number of young adults who met other exclusion criteria was unknown when randomization began, as this information was not available in DCF's administrative data system. During the first five months of randomization around 18 percent of age-eligible young adults were determined to meet the program's exclusion criteria.

Combined with a pandemic-related decline of about 200 young people ages 17 to 21 in care, we revised the estimated target population size to 680.

Minimum Detectable Effects

To determine the appropriate sample size for our study, we estimated Minimum Detectable Effect (MDE) sizes. These effect sizes scale the effect of intervention by the standard deviation of the outcome for the control group, normalizing the size of the impacts across outcomes. At approximately one year following program entry, the prior RCT evaluation of LifeSet in Tennessee found effect sizes between 0.12 and 0.17 (Valentine, Skemer, and Courtney 2015). An evaluation of a program in Massachusetts that used specialized caseworkers for young adults in extended foster care found effect sizes of 0.38 and 0.39 for impacts approximately two years following program entry (Courtney et al. 2011).

We calculated MDEs for this study using an alpha of 0.05, 80 percent power, and R^2 of 0.30. Our MDE for administrative data outcomes is 0.193.[17] Table D.1 presents MDEs for survey data outcomes under three response rate scenarios.

TABLE D.1

MDEs for Survey Data Outcomes

Response rate	Treatment sample size	Control Sample size	MDE
70%	268	194	.221
60%	230	166	.239
50%	192	139	.262

Source: Urban Institute calculations.

Referral and Randomization

DCF determined during biweekly meetings with LifeSet implementing organizations the anticipated treatment group slots that would become open in the following two to four weeks. Identification and referral of target young adults was completed by DCF based on administrative records and information

[17] MDE calculation excludes 49 sample members who declined consent to obtain their administrative data. See "Administrative Data Consent Process and Rates" section in appendix D for detailed description.

gathered from young adults' caseworkers. The list was pulled monthly; then sorted first by implementing organization region and then in descending order of young people's age in days.

An administrator in DCF's OAS conducted eligibility screening on a rolling basis as program slots became open. The OAS administrator conducted a secondary screening by contacting the caseworkers for young adults deemed eligible based on administrative records to obtain caseworker confirmation that the young adult did not meet any exclusion criteria. The OAS administrator worked down the administrative data list in descending order of age until, at minimum, enough young adults met study criteria to fill both the treatment spots and the associated number of control spots. Young people who did not receive a secondary screening due to a lack of study slots were merged with the next month's administrative data pull and resorted by region and age, so long as they met initial eligibility criteria.

DCF sent the list of eligible young adults and the number of study slots needed per region to the Urban project team, who performed the random assignment and sent back to DCF the list of young adults with their group assignment. DCF then referred young adults in the treatment group to a LifeSet implementing organization; young adults in the control group were referred to, or continued receiving, services as usual.

For young adults deemed ineligible for LifeSet, DCF collected detailed information on reasons for this determination and provided this information to the Urban project team. Young adults deemed ineligible due to temporary (i.e., nonstatic) exclusion criteria could reenter the randomization pool if the exclusion no longer applied at the time of the next data pull. Young adults were temporarily excluded if they did not reside in one of the counties served by the LifeSet implementing organizations, were on missing status (i.e., unlocatable), or if they were not currently residing in the community (e.g., hospital, incarceration, specialized residential home) and were not expected to return to a community setting within the next 30 days.

As shown in figure 2, 23 percent of young adults screened by DCF were excluded either permanently or temporarily when randomization concluded. Most young adults were screened out due to having an intellectual or developmental disability or not having an open case. A greater percentage of males were screened out than females (32 percent versus 18 percent, respectively).

Only 60 percent of young adults in the treatment group had enrolled in LifeSet during the first five months of randomization. This led to DCF referring young adults for randomization at a faster rate than expected to fill program slots. At the same time, the DCF identified the reduction in the target population discussed above. This increased the risk that there would not be enough eligible young people to keep all the program slots filled while also maintaining the original control group of 300 young

adults. In March 2022, we changed the randomization ratio within each implementing organization stratum to 2T:1C to fill program slots and allow as many eligible young people to receive LifeSet while still maintaining a randomized control group.

To assess whether only young adults in the treatment group enrolled in LifeSet, we used program data entered by the LifeSet service implementing organizations into Youth Villages' data system. The randomization list was matched to the LifeSet enrollment data on young people's study ID and date of birth. The matching process indicated that only young adults in the treatment group received LifeSet. No young adults in the control group nor any nonrandomized young adults received LifeSet during the study intake period.

Allocation

We randomized a total of 661 eligible young adults with 384 of them assigned to the treatment group and 277 assigned to the control group. Table D.2 shows the randomization counts for the study overall and by region. The share of young adults in the study was not equal across implementing organizations, despite each organization having one LifeSet team that could serve 32 to 40 young adults at a time. Program administrators for all implementing organizations stated during interviews that their teams had experienced at least some turnover in LifeSet specialists over the 19-month randomization period. Differences in the turnover rate across organizations may explain some of the variance as organizations with fewer staff also had fewer available program slots over the course of the randomization period.

TABLE D.2

Randomization Counts for the Study

Region	Randomized *N*	Randomized %	Treatment *N*	Treatment %	Control *N*	Control %
Region A	160	24%	93	14%	67	10%
Region B	201	30%	117	18%	84	13%
Region C	166	25%	97	15%	69	10%
Region D	134	20%	77	12%	57	9%
Study total	661	100%	384	58%	277	42%

Source: Urban Institute analysis of randomization data.

Baseline Young Adult Survey Consent Process and Response Rates

Survey Consent Process

We randomly assigned young adults to receive a referral to LifeSet or continue receiving services as usual before obtaining consent or assent for young adults' participation in evaluation data collection. We asked for consent in this order as DCF was concerned that randomizing young adults only after they expressed interest in LifeSet would result in young people feeling they were denied a service they wanted and needed. Randomizing the offer of receiving LifeSet also allowed us to better assess what the take-up rate would be if the state offered the program to all eligible young adults and learn who is most likely to enroll in the program.

Per Title 45, Part 46 of the Code of Federal Regulations, the Urban Institute's Institutional Review Board (IRB) approved a waiver of informed consent for randomization because the following conditions were met: (1) The research involved no more than minimal risk to the subjects; (2) the waiver or alteration did not adversely affect the rights and welfare of the subjects; and (3) the research could not practicably be carried out without the waiver or alteration. All randomized young adults were asked to provide active, affirmative informed consent for data collection activities not covered by the waiver, such as the survey interviews. In addition, young adults randomized to the treatment group could choose whether to participate in LifeSet and retained access to all other services from DCF to which they were eligible. All consent procedures were also approved by DCF's Research Review Committee.

During the survey consent process, young adults were not told if they were in the control group or treatment group. Information about the LifeSet program was also not given during the consent process. Instead, young people were asked for consent to participate in the "Young Adult Services Study." DCF shared the contact information for all randomized young adults with Urban, who sent this information to our contracted independent survey firm, RTI International (RTI), to collect young adult survey data. RTI attempted to contact all randomized young people to seek informed consent or assent for the young adult's participation in evaluation data collection. All young adults who met with an RTI field interviewer were asked to consent or assent to participate in the baseline survey and to future contact for additional survey waves, interviews, and focus groups.

Survey Response Rates

Response rates were similar between the treatment and control groups, with the treatment group having only a slightly higher response rate than the control group (61 percent versus 58 percent), but that difference was not statistically significant. In table D.3, we compare baseline survey respondents and nonrespondents through demographic characteristics to identify any potential nonresponse bias. Although the survey asked about race/ethnicity and sex assigned at birth, we used administrative data from DCF to analyze these characteristics for both survey respondents and nonrespondents. Controlling for any systematic differences between respondents and nonrespondents can reduce observable nonresponse bias.

Response rates were similar for young adults ages 18 to 21. They were lower for young people age 17, but there were only ten 17-year-olds in the sample. Response rates were similar across all racial/ethnic groups. The response rate for females was statistically higher than that of males ($p = 0.04$).

TABLE D.3

Demographic Characteristics of Baseline Survey Respondents versus Nonrespondents

	Respondents *N*	Respondents %	Nonrespondents *N*	Nonrespondents %	Total *N*
Group assignment					
Treatment	235	61%	149	39%	384
Control	160	58%	117	42%	277
Age at randomization					
17	3	30%	7	70%	10
18	147	62%	91	38%	238
19	128	58%	92	42%	220
20	108	60%	71	40%	179
21	9	64%	5	36%	14
Race/ethnicity					
Black, not Hispanic	158	59%	109	41%	267
White, not Hispanic	68	54%	57	46%	125
Other race, not Hispanic	15	58%	11	42%	26
Hispanic, any race	104	54%	89	46%	193
Sex					
Male	124	51%	117	49%	241
Female	222	60%	149	40%	371

Sources: LifeSet evaluation baseline young adult survey data and New Jersey Department of Children and Families administrative data.
Note: Data for race/ethnicity and sex exclude 49 young adults who declined consent to access their administrative data and 1 young adult who declined to share their race/ethnicity in the administrative data.

In addition, the response rate for those in the treatment group who subsequently enrolled in LifeSet was significantly higher than for those who did not enroll (65 percent versus 44 percent, $p < 0.01$). Respondents spent an average of five months in congregate care, significantly longer than nonrespondents' average of three months ($p = 0.05$). There were no other significant differences between respondents and nonrespondents in their child welfare histories.

Table D.4 provides survey response rates for each treatment group by region. Overall response rates were similar for three of the four implementing organization areas (52 percent to 62 percent). The region with the lowest response rate (Region D at 52 percent) was also the region with the greatest share of males in the sample.[18] Males made up 48 percent of young adults in the study in Region D but only around one-third of young adults in two other regions and two-fifths in another region (appendix C). As shown in table D.3, males had higher nonresponse rates than females. Thus, the high share of males may explain why Region D had the lowest response rate.

TABLE D.4
Baseline Survey Response Rates for Treatment Group by Region

Region	Treatment response rate *N*	Treatment response rate %	Control response rate *N*	Control response rate %	Total response rate *N*	Total response rate %
Region A	59	63%	40	60%	99	62%
Region B	77	66%	48	57%	125	62%
Region C	59	61%	42	61%	101	61%
Region D	40	52%	30	53%	70	52%
Study total	235	61%	160	58%	395	60%

Source: Urban Institute analysis of randomization and survey data.

Administrative Data Consent Process and Rates

Young adults who were at least 18 years old at the time of their baseline interview were asked to provide consent for administrative data access and linkage. Young people who were 17 years old at the time of their baseline interview were not asked for consent to access administrative data. Rather, these

[18] DCF was not aware of any reason why Region D would have more males.

young people will be asked to provide consent for administrative data access and linkage during the follow up survey wave.

Near the end of baseline survey collection, we received from Urban's IRB a waiver of informed consent to access administrative data for randomized young adults who did not actively decline consent. As detailed in the next section, COVID-19 restrictions required most data collection to occur by phone, which limited RTI's ability to inform young adults about the study. A total of 49 young people (7 percent overall; 7 percent control, and 8 percent treatment) actively declined consent for administrative data access.

Data Sources and Measures

Baseline Young Adult Survey

Many items on the CalYOUTH survey were from existing standardized measures or from other large surveys of young adults. We modified items related to current living arrangements to fit the New Jersey program and context. See appendix A for a full list of source citations. The youth resilience section of the Youth Thrive™ Survey contains 10 statements (e.g., "I learn from my mistakes," "I try new things even if they are hard"), and the social-emotional competence section contains 16 statements (e.g., "I am a dependable person," "I get along well with different types of people"). Each section uses a Likert-type scale (i.e., not at all like me, a little like me, sort of like me, a lot like me, very much like me) where respondents indicate the extent to which each statement describes them. Section scores are generated by assigning values of 1 to 5 to the rating scale (i.e., 1 = not at all like me, 5 = very much like me) and calculating the total for each respondent and the average across all respondents. Negatively worded items (e.g., "I give up when things get hard") were reverse scored. One item in the youth resilience section and three items in the social-emotional competence section were reverse scored. Cronbach's alpha for the youth resilience section and social-emotional competence section was 0.877 and 0.844, respectively. These values suggest high internal consistency and reliability among items within each section.

We also used items from the Conflict Tactic Scale (CTS) to assess young adults' engagement in or experience of intimate partner violence. The CTS includes 39 items that ask about the frequency of physical and psychological abuse, either experienced or perpetrated by the respondent (e.g., "I slapped my partner," "My partner did this to me.") For the purposes of our survey, we combined individual-scale items into single questions (e.g., "How often has your spouse/partner slapped, hit, choked, or kicked, pushed or shoved you, or thrown something at you that could hurt during the past year?"). The survey

used four items from the CTS: two items asked about experiencing physical or sexual violence and two items asked about perpetrating physical or sexual violence. Each item had seven response options ranging from never in the past year to more than 20 times in the past year. Only respondents who indicated they had a partner at the time of the survey were shown survey items related to spouse or partner violence. Respondents who answered affirmatively to experiencing any CTC item were indicated as experiencing domestic violence in the past year.

SURVEY COLLECTION PROCEDURES

Baseline survey collection began in November 2021, three months after the start of randomization, as the project awaited approval from the OMB. A total of 140 young adults were randomized before the start of the baseline survey collection. In addition, there were challenges during data collection due to the COVID-19 pandemic. From November 2021 into August 2022, RTI conducted survey outreach solely by postal mail, phone, and email and all survey interviews by phone. [19]

RTI implemented multiple strategies to increase phone response rates such as mailing study information in a blue greeting card–sized envelope, contacting young adults' DCF caseworkers to obtain new contact information and encourage response, and sending text appointment reminders (with young adults' permission). Common challenges experienced by field interviewers during phone data collection included respondents

- not answering their phone nor returning voicemail messages,
- hanging up, often before interviewers could tell them about the study,
- scheduling appointments to complete the survey and then not answering their phone at the appointed time, and
- having inconsistent cell phone service.

The Urban Institute IRB approved in-person data collection in July 2022 only when a county's COVID-19 risk level was low or medium per the Centers for Disease Control's weekly metrics. When a county's risk level was high, all data collection in that county was done by phone until the risk level was lowered.

[19] The survey data were collected by trained RTI field interviewers using computer-assisted personal interviewing and computer-assisted telephone interviewing technology to reduce measurement error. Additionally, audio computer-assisted self-interviewing was used during in-person surveys to allow participants to privately answer the most sensitive items and prevent social desirability bias in responses.

SURVEY TIMING

Both the delay in the start of baseline data collection and COVID-19-related restrictions impacted the time between when a young adult was randomized and when they completed the baseline survey. Table D.5 provides summary statistics on the time between random assignment and baseline survey completion. Half of respondents completed the survey about 2.5 months after randomization with a mean time of about 3.5 months. These delays are likely related to the fact that 21 percent of the sample was randomized during the three-month window before survey collection began.[20]

TABLE D.5

Summary Statistics on the Time between Randomization and Baseline Survey Completion

Time between randomization and baseline survey completion in days	Total (*n* = 395)	Treatment (*n* = 235)	Control (*n* = 160)
Mean	105.44	102.09	110.36
SD	90.54	90.33	90.9
Median	78	75	80.5
Within 30 days	70 (18%)	48 (20%)	22 (14%)
31–60 days	90 (23%)	53 (23%)	37 (23%)
61–90 days	62 (16%)	36 (15%)	26 (16%)
91–120 days	46 (12%)	24 (10%)	22 (14%)
121 or more days	127 (32%)	74 (32%)	53 (33%)

Source: Urban Institute analysis of randomization and survey data.

The delay in baseline data collection and COVID-19 restrictions on in-person data collection also impacted the time between when young adults in the treatment group enrolled in LifeSet and completed the baseline survey. Most young adults in the treatment group who completed the survey did so after enrolling in LifeSet, due in large part to the three-month lag between start of randomization and baseline survey collection. Of the 156 young adults in the treatment group who enrolled in LifeSet and completed the survey, 135 (87 percent) completed the survey after LifeSet enrollment, 19 (12 percent) completed the survey before LifeSet enrollment, and 2 (1 percent) completed the survey and LifeSet enrollment on the same day. For those who took the survey after LifeSet enrollment, the mean time between the two events was 91 days with a median time of 64 days. In other words, half of these young adults had been receiving LifeSet services for two months or less before completing the baseline survey.

[20] The mean time between randomization and baseline survey completion for those who were randomized after baseline survey collection began (*n* = 285) was 84.99 days, and the median time was 56 days.

ITEM MISSINGNESS

The rate of item-level missingness was very low for those who completed the survey. Items were missing if the recorded response was "don't know" or "refused" or if there was no response recorded when one should have been. About 84 percent of items had a missing rate of less than or equal to 1 percent. Around 7 percent of items had a missing rate greater than or equal to 5 percent.

Two items that asked about income from formal and informal employment in the past 12 months had a high rate of missingness at 39 percent for formal employment and 19 percent for informal employment. These two items asked respondents to provide their income in a dollar amount. Respondents who could not provide a dollar amount received a follow-up item asking them to select an income range for a set of options. Missingness was 4 percent on the formal income range item and 0 percent on the informal income range item. When the income in dollars and range items were assessed together, the overall missingness for formal income was 1 percent and 0 percent for informal income.

Other items with missing rates of more than 5 percent were

- race at 7 percent,
- last month of school enrollment (for respondents not currently in school) at 8 percent, and
- contacted to participate in LifeSet (for treatment group respondents) at 7 percent.

We did not use any form of imputation to fill in missing data because this report only presents descriptive analyses.

DCF Administrative Data

We received administrative data related to demographics and child welfare history from DCF for randomized young adults who did not actively decline consent. We used these data to answer research questions related to baseline equivalence and to describe the characteristics of young adults that enrolled in LifeSet. Young people's child welfare experiences, such as the number and types of placements they had been in, may impact their ability to successfully transition out of foster care. To construct measures of these experiences, we used administrative data on child welfare history, as it is more reliable than young adult self-report.

The administrative data received included demographic data, removal and placement dates, removal reasons, discharge reasons, placement types, and receipt of independent living stipends. Forty-

nine young adults who responded to the survey actively declined consent for the project team to access their administrative data.

DATA QUALITY

We assessed quality of the DCF administrative data by examining rates of item and unit (i.e., child-level) missingness and assessing date logic where applicable. Demographic data related to sex, date of birth, and Hispanic ethnicity were complete with no unit or item missingness. One case (0.2 percent) was missing data related to race. Data files related to removal and placement history had no item-level missingness. However, 30 young adults had no removal data (5 percent of the sample), and data for an additional six young adults (1 percent) indicated their first removal episode occurred after age 18. Our conversations with DCF confirmed that in 29 cases young adults had never been removed (i.e., placed in DCF custody). In the remaining one case, the young adult was placed in New Jersey through an Interstate Compact on the Placement of Children (ICPC); thus, their removal and placement data are not accessible to New Jersey. When combined with the one young adult placed in New Jersey through ICPC, 30 young adults were excluded from analyses related to removal and placement history.

Discussions with DCF clarified that removal history is not a requirement for young adults to have a voluntary services case after age 18. These 30 young people were eligible for voluntary services due to their receipt of in-home or behavioral health services through DCF at age 16 or older. Discussions with DCF also clarified that creating a removal episode is the only means to document cases where the state agency is providing placement and paying a providing agency for a young adult. Additionally, the completeness of placement data for placements after age 18 may depend on whether or not DCF pays for the placement. DCF typically documents placements after age 18 if they pay for the placement; however, data for placements after age 18 may be less reliable if DCF is not directly paying for the young adult's living arrangement. Data related to voluntary services case history was low quality and not used for analysis. Data were missing for 165 (27 percent of) young adults. In addition, 34 percent of cases had voluntary case opening dates before the young person's 18th birthday. DCF clarified that nothing in the data system triggers or requires converting a placement case to a voluntary services case when the young person turns 18. If the young person remains in the same placement and continues receiving payments after age 18, most workers simply keep the removal case open in the data system.

Youth Villages Program Data

We received program data from Youth Villages related to LifeSet enrollment for young adults in the study and certification scores for the four LifeSet implementing organization agencies.

ENROLLMENT DATA

LifeSet implementing organizations must enter information related to program enrollment into Youth Villages' data system. These data were used to answer research questions related to the LifeSet enrollment rate of young adults in the treatment group and the characteristics of those who enrolled versus those who did not. The enrollment data included LifeSet enrollment dates, discharge dates, and enrollment implementing organization for all randomized young adults beginning in August 2021 through January 2024. Enrollment data were excluded for the 49 young adults who declined to share their administrative data. Data quality appeared good in that there were no missing dates for young adults in the treatment group who did enroll and start and end dates of program participation did not overlap. Additionally, the data confirmed no young adults in the control group enrolled in LifeSet during the study period.

CERTIFICATION SCORES

We used Youth Villages' certification scores for the four LifeSet implementing organizations to assess the research question on whether LifeSet was delivered as intended in New Jersey. Youth Villages conducts an initial six-month certification review of agencies that provide LifeSet, after which reviews are conducted on an annual basis. Youth Villages has conducted four certification reviews of each implementing organization since the start of program implementation in New Jersey: a six-month baseline certification was completed in spring 2021 and annual certifications were completed in fall 2021, 2022, and 2023.

Annual certifications contain two subscores—one focused on operations and another on clinical implementation—that are combined into an overall score. The six-month baseline certification only includes the clinical subscore. The clinical subscore includes a review of cases within a random six-month period of the past year. Documentation is reviewed related to group supervision, staff development, service plans, and safety plans. The clinical subscore also includes young adult and staff surveys administered by Youth Villages.

The operations score reviews an entire year's performance. It mostly consists of LifeSet's key performance indicators (KPIs), but also includes items related to risk and financial management (e.g., workers' compensation, compliance documents) and program sustainability. LifeSet KPIs include metrics related to the number of young adults served (e.g., average daily census, staff caseload), serious incidents (e.g., incident rate, reporting rate), process measures (e.g., session completion), discharge outcomes (e.g., length of stay, housing status, criminal justice involvement), and staffing (e.g., turnover, tenure). Implementing organizations enter or upload these KPI data into Youth Villages' GuideTree

platform weekly. Licensed program experts review the KPIs with implementing organizations monthly. Regional network leads review the KPIs with the program lead at each implementing organization during monthly data calls.

The maximum score both overall and on each subscale is 100. An overall score of 80 percent is the minimum required for a partner agency to be considered implementing LifeSet with fidelity. Partner agencies that fall below this threshold require a performance improvement plan and a satisfactory midpoint review before their next annual review to remain certified. Agencies are also expected to meet the 80 percent threshold for every individual measure scored, with the exception of two operations measures—related to sessions held and full staffing—that must meet a 90 percent threshold. A performance improvement plan must be completed for any individual measures below the required threshold even if the overall score meets or exceeds 80 percent. Per Youth Villages, the average certification scores across all partners and review types since 2020 were 85 percent overall, 86 percent for the clinical subscore, and 81 percent for the operations subscore. We triangulated certification review scores and information gathered from interviews and focus groups to assess fidelity of LifeSet's implementation in New Jersey.

Interview and Focus Group Data

We conducted interviews and focus groups with program administrators, LifeSet staff, and young adults in the treatment group to gather their perspectives on the implementation of LifeSet in New Jersey. We used interview and focus group data to answer research questions related to how LifeSet differs from usual services; how eligible young adults were identified, recruited, and enrolled in LifeSet; and if LifeSet was being delivered as intended. Most interviews and focus groups were conducted virtually via Zoom due to COVID-19 pandemic restrictions on in-person data collection. All interviews and focus groups used semistructured protocols led by Urban researchers.

Staff and administrator protocols covered a variety of topics related to LifeSet's implementation in New Jersey, such as reasons for bringing LifeSet to the state, the implementing organization selection and training process, how young adults were enrolled in the program after referral, common needs and challenges of young adults, how implementing organizations carried out LifeSet with young people, and successes and challenges staff experienced in implementing LifeSet.

We also conducted individual and paired interviews with 11 young adults in the treatment group who had received LifeSet and 3 young adults in the control group. Young adult protocols covered a variety of topics related to their perceptions of and experiences in LifeSet and DCF services in general,

including their first impressions of LifeSet, their relationships with LifeSet specialists and DCF caseworkers, what activities they did in LifeSet, the types of support received, and what they liked and disliked about the program. Young adult protocols also asked young people about their general experience aging out of foster care, such as challenges experienced, what types of support have been most helpful, additional supports needed, and what accomplishments they were most proud of. Only young adults in the treatment group were asked the LifeSet items.

Interviews and focus groups were audio recorded. Verbatim transcripts were coded and analyzed in NVivo by several members of the Urban research team. Codes were reviewed and organized into key themes and issues to answer the research questions about LifeSet implementation. Although the protocols covered a range of topics and included interviews with young adults in the control group, only the subset of data relevant to research questions noted above is included in this report.

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