

Findings from the National Survey of Child and Adolescent Well-Being (NSCAW): Clinical Lessons Learned

Richard P. Barth
School of Social Work
University of Maryland

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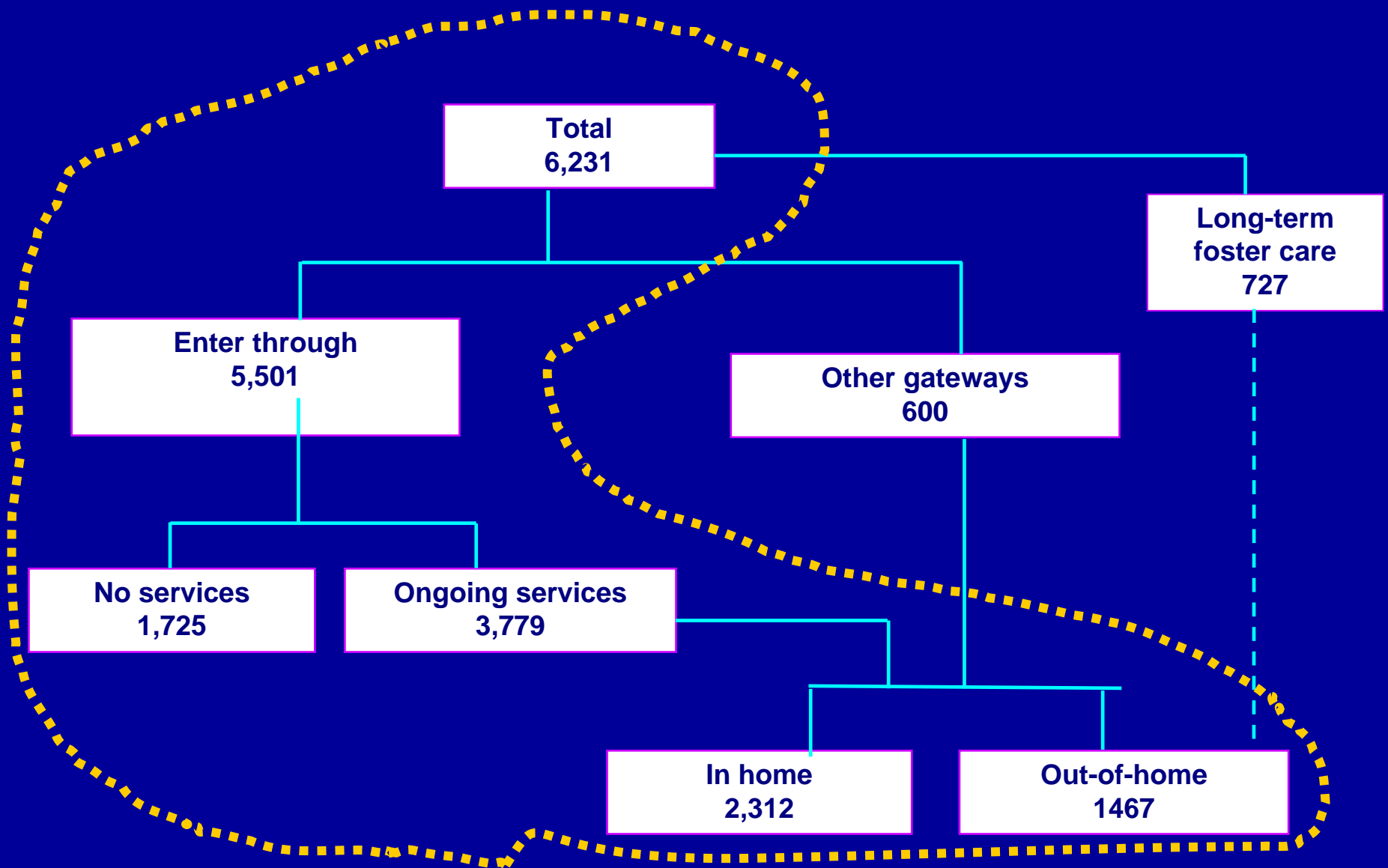
Research Studies Reviewed

- Overview of NSCAW
- Child Maltreatment Recurrence
- Youth Attitudes Toward Permanency
- Substance Abuse Treatment and Reabuse
- Family Group Decision Making
- Parent Training
- Children's Attitudes About Permanency

National Survey of Child and Adolescent Well-being (NSCAW)

- Funded by the Administration on Children, Youth, and Families of the U.S. DHHS
- First National Random Sample Study of CWS
- Longitudinal, national probability study of children and families investigated for child maltreatment
- Two-stage stratified sample
 - primary sampling unit: county child protective service agencies
 - secondary sampling unit: families with a completed investigation for child maltreatment within the agency.

NSCAW Cohort at Baseline



Strengths and Weaknesses of NSCAW for Clinical Inference

STRENGTHS

- Better measurement than is available from administrative data (including self-report)
- More independent (objective) measures than might be available in some clinical settings
- Longitudinal

WEAKNESSES

- Panel study—not a clinical trial
 - Bias selection into services—more challenged children and families get more services but may still do worse
 - Used statistical methods to try to make results clinically meaningful

Child Maltreatment Recurrence among Children Remaining In-home: Re-reports, Caregiver and Youth Self-report, and Underreporting

Now published as

Kohl, P. & Barth, R.P. (2007). Reentry, reabuse, and reinvolvement of maltreated children: Findings from the National Survey of Child and Adolescent Well-Being. In R. Haskins, F. Wulczyn, & M. B. Webb (Eds.). (pp. 207-225). *Child protection: Using research to improve policy and practice*. Washington, DC: Brookings.

Official Re-reports of Maltreatment

- Many children have new maltreatment reports following child welfare involvement (Fluke, Yuan & Edwards, 1999; Lipien & Forthofer, 2004; Marshall and English, 1999; U.S. DHHS, 2005; Wells, 1995)
- Estimates vary
 - About a quarter have any re-report
 - Between 5% and 11% of all cases have a substantiated re-report
 - One study had a rate of 26%

Self Report of Physical Abuse

- Official re-reports are the common way to measure maltreatment
 - Substantiated re-reports are used by NCANDS
- Not all maltreatment is brought to the attention of child welfare agencies
 - Only 28% of children with identified abuse had an official maltreatment investigation (Sedlak & Broadhurst, 1996)
 - Maternal self report resulted in an incidence rate of physical abuse 40x greater than the rate of official reports (Theodore et al., 2005)

Overview of Study

Purpose: To extend the current knowledge base on recurrent maltreatment through the examination of re-reports, multiple re-reports, substantiated re-reports, and unreported abuse identified by adolescents and caregivers.

- Subset used for this study:
 - Children remaining in-home following the index maltreatment investigation
 - $n = 3143$

Official Re-reports in 18-Months

- 23% of children had at least one re-report
 - 1 re-report (56%)
 - 2 re-reports (30%)
 - 3 re-reports (7%)
 - 4 or more re-reports (7%)
- Younger children (< 6 years old) and families receiving CWS were more likely to have multiple re-reports ($\chi^2, p < .05$)

Predictors of Any Re-report

Re-report was *more* likely for families...

- with prior reports of maltreatment (OR = 2.30, $p < .01$)
- received CWS following index report (OR = 1.52, $p < .10$)
- whose child has higher behavior problems (OR = 1.03, $p < .01$)
- with higher frequencies of domestic violence (OR = 1.01, $p < .05$)
- with caregiver history of abuse and neglect (OR = 1.90, $p < .05$)
- with higher doses of parenting services (OR = 1.19, $p < .01$)

Re-report was *less* likely for families...

- in non-urban areas (OR = 0.56, $p < .01$)

Unweighted n = 1542; NS variables in the logistic regression model were child age, child gender, child race/ethnicity, prior CWS, maltreatment type, substantiated index report, caregiver mental health and substance abuse problems, trouble paying for basic necessities, poverty.

Outcome of Re-reports

- Among all children with at least one re-report, 38% had at least one substantiated re-report
- 30% of *all* re-reports were substantiated
- 52.5% of families did not receive any child welfare services following re-report
- 92% of children *remained in home* over the entire study period

Convergence between Self-Report and Official Report of Maltreatment

| Children with Caregiver or Self-reported Physical Abuse | Percentage of Self Reported Physical Abuse Cases with an Official Maltreatment Report (SE) | |
|---|--|---------------------------------|
| | Official Maltreatment Report | No Official Maltreatment Report |
| Youth Report | | |
| 11 and older (n = 106) | 24.6 (5.6) | 75.4 (5.6) |
| Caregiver Report | | |
| 0 – 2 (n = 67) | 9.7 (6.1) | 90.3 (6.1) |
| 3 -5 (n = 38) | 26.7 (12.2) | 73.3 (12.2) |
| 6 – 10 (n = 69) | 42.2 (10.0) | 57.8 (10.0) |
| 11 and older (n = 63) | 30.6 (10.3) | 69.4 (10.3) |

Unweighted N's are reported; however, all analysis is on weighted data

About 10% of infants with caregiver reported physical abuse had an official re-report

Summary

- Many children have re-involvement with CWS
 - Yet, subsequent physical abuse of many children remains unreported
- Age is related to recurrent maltreatment
 - Younger children are at most risk for multiple re-reports *and* unreported physical abuse
- Re-reports are more likely to be substantiated than original reports
 - 8.7% of children in study have substantiated re-report
- Over half of families *do not* receive CWS following re-reports
 - Families with more re-reports are *less* likely to have their case closed to services

Summary (2)

- Children with more behavior problems have a greater likelihood of re-report
- Maltreated children exposed to DV are a risk of re-report
- Services (both CWS and parenting support services) are associated with re-report
 - Possible explanations include:
 - 1) Families with greater needs selected into services – *selection bias*
 - 2) Agency surveillance
 - 3) Services may not adequately address the family's needs
- Parenting services reduce the risk of unreported physical abuse among infants
- Urban areas have more unreported abuse

Implications

- Many children in families whose cases were open to CWS have new maltreatment reports
 - The functions of these re-reports are poorly understood
 - They may serve different roles for different types of cases
- Structured risk assessment instruments with proven validity should be used by child welfare workers
- Assessment of physically abusive discipline tactics is warranted during *all* maltreatment investigations
- Domestic violence must be identified and addressed
- Need rapid development of evidence-based parent training programs for families involved with CWS, especially for families struggling with child behavior problems

Children's Changing Perceptions of Out of Home Care

Mimi V. Chapman, MSW, Ph.D. & Sharon Christ, MS, PhD

The University of North Carolina at Chapel Hill

mimi@unc.edu

Why Focus on Children's OOH Care Experience?

- We know little about it
- Our baseline findings ran counter to general public perceptions of OOH care*
 - Children were positive about their caregivers
 - Yet, they expressed a strong desire to remain connected to their biological families
- We wanted to know if we could learn more about the variety of experiences in this large group
- Do perceptions change over time?

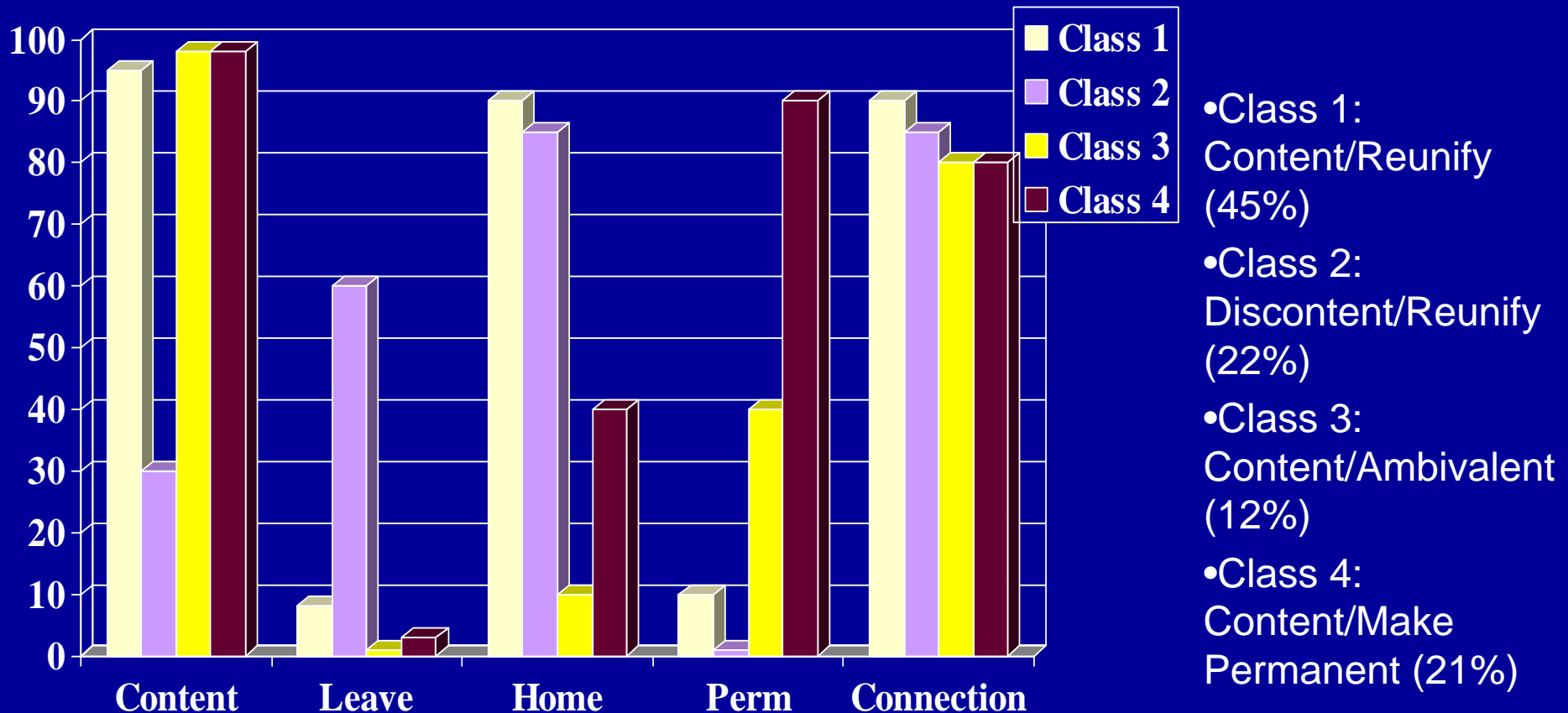
Participants

- Youth (7 years and older) in OOH care at Baseline (n=608)
- Those who remained in care 18 months following the investigation (n=396)
- 52% were over 11 years old.
- 45% were male
- 34% African-American, 49% White, 10% Hispanic, 7% other.
- 32% family foster care, 44% kinship care, 15% group/other

Clustering Questions

- Like caregivers?
- Part of the Family?
- Can live there until grown-up?
- Think they will live in the same place next year?
- Tried to leave/runaway?
- Think they will live with their parents again?
- Things with their parents will be different next time?
- Wants placement as permanent home?
- Wants to be adopted by current caregiver?
- Avoids family visits?
- Wants to see other family members?

Class Comparison on Conceptual Domains at Baseline



***MAJORITY OF ALL CLASSES WANT CONTINUED CONNECTION WITH AT LEAST SOME MEMBERS OF THE BIOLOGICAL FAMILY**

What Happens over Time? Using Latent Transition Analysis to Examine Changing Attitudes (n=384)

- **Can** live there until **grown-up**?
- Think they will live in the same place **next year**?
- **Wants** placement as **permanent** home?
- **Wants** to be **adopted** by current caregiver?
- Think they will live with their **parents** again?
- Things with their parents will be **different** next time?

Where Were These Children at 18 months Post Investigation?

- About 1/3 had returned home
- Just over half were in kin care or family foster care.
- 16% were in group care or some other arrangement
- 15% had run away
- Other

Summary of Findings

- Upon entering care, most (66%) of children (7 & Up) say they want to return home.
- A sizeable group (34%) does not see home as an option from the beginning.
- Majority of youths' attitudes stay stable over 18 months (60%); 40% will change.
- Most will move from ambivalence or negative attitudes towards more commitment to their current placement.

Clinical Implications

- Children should be asked about their current placement and their hoped for placement
- They may have intense ambivalence
 - This should be assessed
- Children who remain committed to going home and are not content with being in care are more likely to run away if they cannot go home
- Children who do not change their attitude about an alternative placement may need help to conceptualize what that means
- Readiness for adoption or guardianship does grow in time but still may need assistance

Substance Abuse Treatment and the Recurrence of Child Maltreatment: A Propensity Score Analysis

Now published as Barth, R.P., Guo, S. & Gibbons, C. (2006). Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis. *Journal of Substance Abuse Treatment*, 93-104.

PSM analyses were funded by the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program NSCAW data used to illustrate PSM were collected under funding by the Administration on Children, Youth, and Families of the U.S. Department of Health and Human Services. Findings do not represent the official position or policies of the U.S. DHHS.

Background for the Study

- Next to poverty, substance abuse is considered most central reason for CWS involvement
 - Linda Gordon *Heroes of Their Own Lives* (1800s)
 - ACF *Building Common Ground* (1999)
 - SAMSHA and ACF National Resource Center on *Child Welfare and Substance Abuse* (2003)
- Largest population of children who receive child abuse reports remain at home, but almost all CWS and SAT research is about placement into out-of-home care

Research Question

- Does substance abuse treatment for caregivers affect the risk of child maltreatment re-reports...
 - ... by caregiver and family?
 - ... by caregiver alone?

Rationale for Comparing Outcomes Using Propensity Score Matching

- Some who could use substance abuse treatment (SAT) receive it and some do not.
- Individuals selected into treatment and nontreatment groups have potential outcomes in both states:
 - the one in which they are observed and
 - the one in which they are not observed (Winship & Morgan, 1999).
- Propensity Score Matching allows estimation of how someone in the unobserved state would do if they were in the observed state

PSM in a Nutshell

- Employs a predicted probability of group membership—e.g., treatment vs. control group--based on observed predictors, usually obtained from logistic regression to create a counterfactual group
- Propensity scores may be used for matching and as covariates in secondary analysis

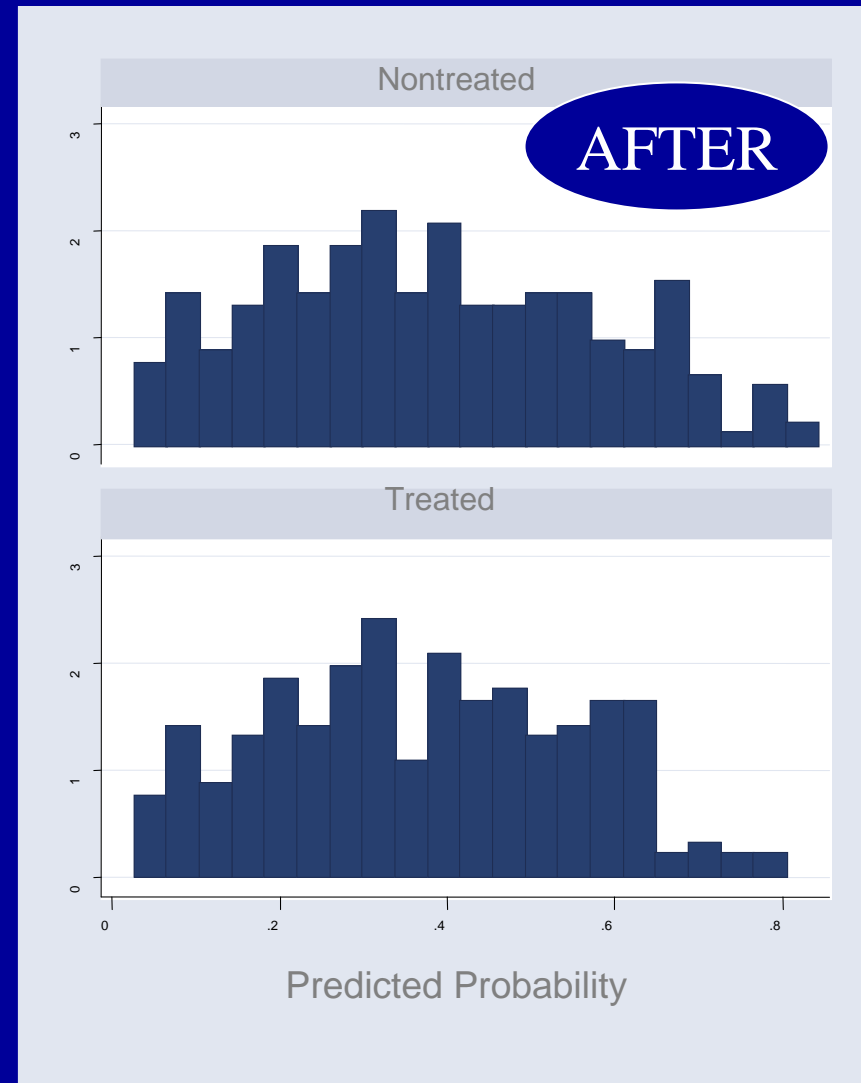
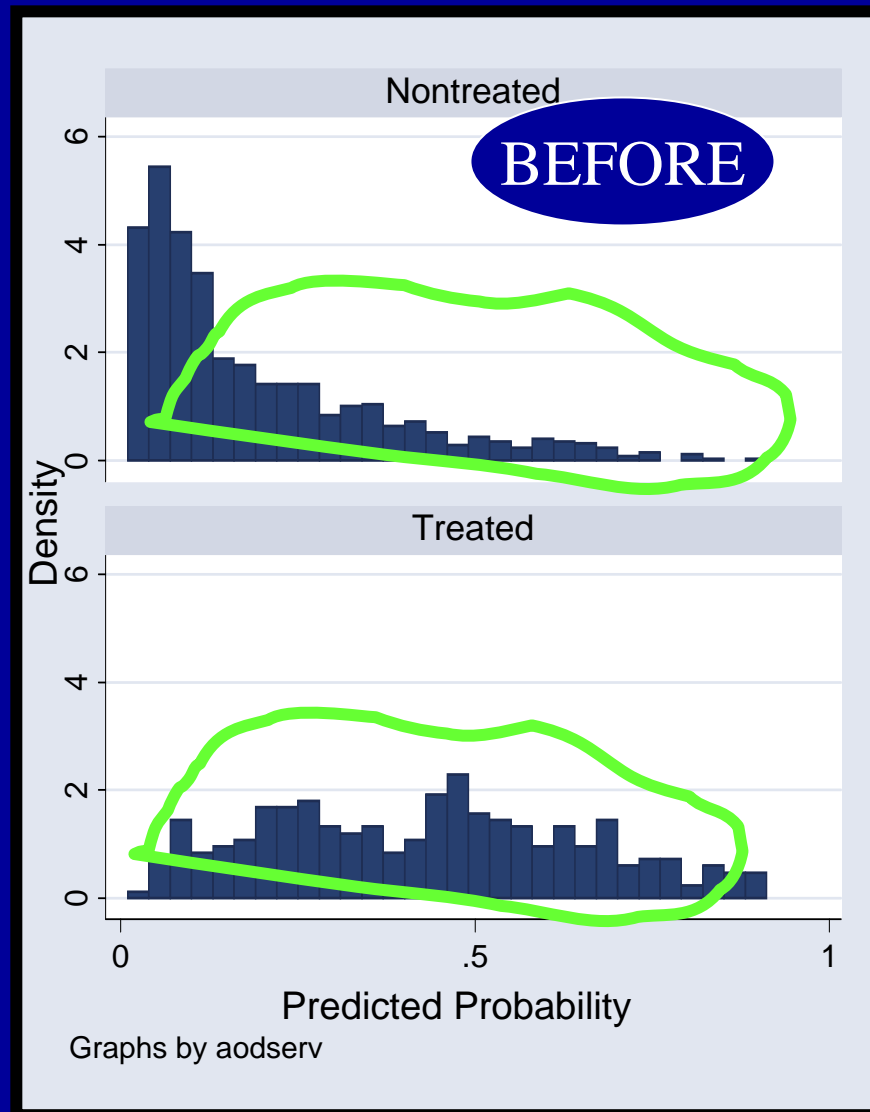
Data & Study Sample

- NSCAW data from two waves: baseline (1999-2000) and the 18-month follow-up.
- The sample for this study was limited to families where:
 - children lived at home (n=4034)
 - primary caregivers were female (n=3670)
 - the primary caregiver had at least one indicator of a substance abuse problem (n=1472)
 - there was a non-missing value of AOD service receipt and a non-missing value of time to first re-report (n=1074)
- Of these children, 276 (26%) formed the “treatment” group, and 798 (74%) the potential comparison group.

Creating the Propensity Score: Dependent Variable

- AOD service receipt
 - Stayed overnight in AOD treatment program
 - Gone to clinic or doctor for AOD
 - CWW reports CG received treatment
 - CG reported “currently receiving treatment”

Histogram of Predicted Probabilities of Using SAT By Treatment Group Before and After Matching



Sample Comparison: Demographics*

| | Before matching (n=1074) | After matching (n=276) |
|----------------------|-----------------------------|---------------------------|
| Child race | p=.02 | p=.50 |
| Child age | p<.0001 | p=.96 |
| Caregiver age | p=.42 | p=.98 |
| Education | p=.03 | p=.47 |
| Employed | p<.001 | p=.15 |
| Poverty | p=.44 | p=.33 |
| Married | p=.95 | p=1.0 |
| Open CW case | p<.0001 | p=.23 |
| Type of maltreatment | p<.0001 | p=.99 |

*No post-matching differences remained statistically significant

Sample Comparison: Caregiver Risk and Need

| | Before matching (n=1074) | After matching (n=276) |
|--------------------------------------|-----------------------------|---------------------------|
| Trouble paying for basic necessities | p=.05 | p=.90 |
| Mental health problems | p<.0001 | p=.45 |
| Recent arrest /jail time | p<.0001 | p=.63 |
| Prior AOD treatment | p<.0001 | p=.29 |
| Need (risk assessment) | p<.0001 | p=.28 |
| Need (CIDI-SF) | p=.0008 | p=.08 |
| Need (caregiver report) | p<.0001 | p=.29 |

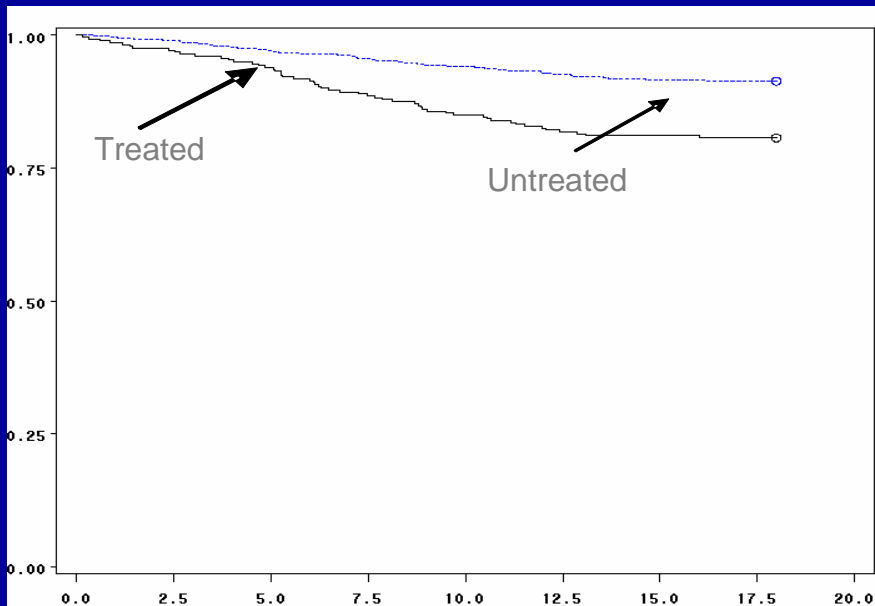
Comparing AOD treatment (yes/no)

Analysis: Kaplan Meier and Cox Regression

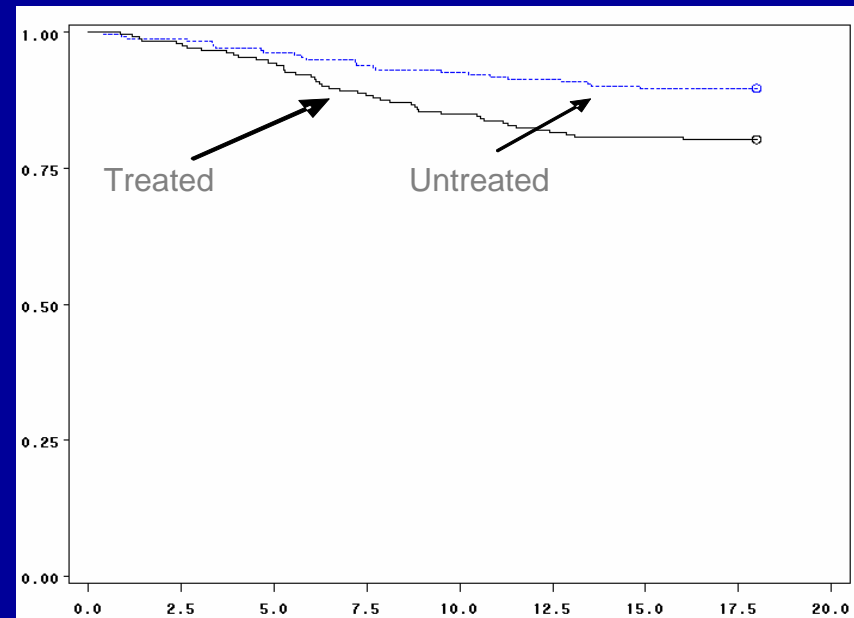
- Dependent variable(s)
 - Time to first re-report (18 month follow-up) by:
 - Caregiver or relative
 - Caregiver alone
- Independent variables for Cox Regression
 - AOD service receipt
 - Child age
 - CG age
 - Prior child welfare services
 - Open child welfare case
 - Family cumulative risk
 - Urban/rural

Percent Children Remaining With No Re-report on Caregivers

Substance Abuse Sample (n=1,074)



Resampled with PSM (n=276)



The proportion of children re-reported within 18-months was higher for SAT after the PSM correction (19 % vs. 9%, $p < .01$), as it was before matching ($p < .001$)

Estimated Hazard Ratios: Cox Regression Based on the Resample

| Variable | Re-report Relative or CG | Re-report Primary CG |
|--|-----------------------------|-------------------------|
| SA Service Receipt (No) | | |
| Yes | 2.02 * | 2.03 * |
| Child Age (11+) | | |
| 0-2 | .60 | .58 |
| 3-5 | .76 | .72 |
| 6-10 | 1.44 | 1.49 |
| Caregiver Age (35 or Older) | | |
| < 35 | 1.51 | 1.66 |
| Prior Child Welfare Service(No) | | |
| Yes | 2.44 ** | 2.51 ** |
| Open Child Welfare Case (No) | | |
| Yes | .77 | .74 |
| Family Cumulative Risk (High) | | |
| Low | .68 | .75 |
| Moderate | .85 | .89 |
| Residence (Nonurban) | | |
| Urban | 1.9 | 1.93 |
| ** p<.01, * p<.05 | | |
| Reference group is shown in parenthesis. | | |

- Whether we use a narrow definition of who was source of new child abuse allegation or not:
- SA treatment group had twice the hazard
- Prior CWS involvement was related, but current Open CWS cases were not related

Conclusions

- Children whose mothers receive substance abuse treatment are more likely to receive a subsequent child maltreatment report in the following 18-months:
 - Whether the source of the report includes all relatives or is restricted to the caregiver, and
 - Whether the selection bias into SAT is controlled for using PSM methods.

Alternate Explanations for Findings

- PSM did not match for important unobserved covariates
- Services may not have been used in full
- Substance abuse services may interfere with parental adequacy
 - Focus is on parent's recovery not child's welfare
 - Time and effort for SAT can be burdensome to parent
- Services may result in greater surveillance which results in more **observed** behaviors that might place children at risk, thus more reports

Implications

- Children whose caregivers receive SAT **may be safer** if the early reports were for failure to participate in substance abuse treatment and prevented abuse or neglect
- Children whose caregivers receive SAT **may be less safe** if the reports followed abuse or neglect
- Caregivers who are involved with SAT may increase their likelihood of remaining involved with CWS, at least for 18-months
- Much more needs to be known about the impact of SAT on child welfare caregivers and children
 - This study suggests that it is not beneficial for reducing maltreatment reports and preserving families

Family Group Decision Making: An Analysis of Services for Children & Caregivers

Elizabeth C. Weigensberg, R. P. Barth, & S. Guo

Jordan Institute for Families

School of Social Work

University of North Carolina

Unpublished paper available from the author

NSCAW data used in this study were collected under funding by the Administration on Children, Youth, and Families of the U.S. Department of Health and Human Services. Findings do not represent the official position or policies of the U.S. DHHS. Contact ecw@unc.edu.

Previous FGDM Research

Previous Research Regarding FGDM

- Inconclusive of case characteristics that are more or less likely to receive FGDM
- Appropriateness of FGDM with sexual abuse or domestic violence cases
- Majority of FGDM participants are family members
- Children who experienced FGDM received more services

Limitations of Prior FGDM Research

- Focus primarily on process and implementation rather than child and family outcomes
- Limited to a specific model or a particular location
- Few long-term, comparative studies

Sample Description

- Total subjects: 3222 children
- Age [mean (SE)]: 7.02 (0.13)
- Gender: 50% male, 50% female
- Race:
 - 47.2% White/non-Hispanic
 - 27.1% Black/non-Hispanic
 - 18.7% Hispanic
 - 9.9% Other
- **11%** (355 children) experienced FGDM meetings at the initial assessment
- **86%** (79) of the 92 PSU's in the NSCAW sample have cases that experienced FGDM meetings

Results: Question 1

Case characteristics

- No significant ($p < .05$) differences among FGDM and non-FGDM cases in regard to the following:
 - Gender
 - Race
 - Reported physical abuse, sexual abuse or neglect due to failure to supervise
 - Prior investigation of child maltreatment
 - History or active domestic violence
 - Caregiver substance abuse

FGDM Meeting Participants

- Percentage (SE) of 355 FGDM cases with each participant present
- Family members: 95.6% (1.3)
 - Mother 86.2% (4.1)
 - Father 43.5% (6.3)
- Family friend/community member: 25.9% (4.7)
- Child welfare agency participants: 95.7% (1.6)
 - CPS investigator 94.8% (1.7)
 - Child welfare supervisor 49.8% (5.9)
- Service providers: 16.2% (4.1)
 - Mental health professionals 12.1% (4.0)
- Other professionals: 36.8% (6.4)
 - Teachers 12.8% (3.3)

Majority of FGDM meetings have family members and CPS investigators present. Service providers, other professionals, and community members participate less often.

Is FGDM Followed by More Services?

- No significant ($p < .05$) differences were found between FGDM and non-FGDM cases in regard to services provided by 36-months

NO DIFFERENCE FOR:

- child mental health and educational services,
- caregiver mental health and substance abuse services,
- domestic violence services,
- parenting services and
- family preservation services

Conclusions

- Cases that experience FGDM are among the most serious in-home cases, given that FGDM cases are more severe, have more types of maltreatment, and are significantly less likely to have a report of neglect due to failure to provide.
- Child welfare agencies are using FGDM for cases involving sexual abuse and domestic violence.
- Family members participated in FGDM meetings for almost all of the cases, indicating that family members are being involved in the decision-making process.
- FGDM cases experienced some increased services in the short-term but after 36-months, FGDM recipients received the same services as those that did not experience FGDM.

Parent Training for Families in CWS

Now published as

Hurlburt, M, Barth, R.P., Leslie, L., Landsverk, J. & McCrae, J.M. (2007). "Building on Strengths: Current Status and Opportunities for Improvement of Parent Training for Families in Child Welfare." In R. Haskins, F. Wulczyn, & M. B. Webb (Eds.). *Child protection: Using research to improve policy and practice* (pp. 81-106). Washington, DC: Brookings Institution Press.

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Parent Training

- Part of the social contract between CWS and families
- One of the most common services—may be provided to as many as 800,000 families each year.
- Relatively little research on or recent policy attention devoted to parent training services for families in child welfare.

Study Data Sources and Methods

- NSCAW data for in-home families receiving child welfare services (N=2,017)
- Key informant interviews with child welfare program managers, Caring for Children in Child Welfare study (N=78)

Organization and Delivery

| | Primary Provider % |
|-------------------------------|--------------------------|
| Child welfare staff | 30 |
| CWS contracted providers | 35 |
| Community based organizations | 27 |
| Mental health agencies | 6 |
| Other | 3 |

Organization and Delivery

| | |
|---|-----|
| Requirement that specific program(s) be used ¹ | 1% |
| Delivered in conjunction with non-CW families ¹ | 84% |
| At least in part, provided at no cost to child welfare by community-based organizations | 61% |

¹ Reported by child welfare worker

Organization and Delivery

- Parent training sessions are typically less than 15 occasions.
- About 72% of parents receive 20 hours or fewer
 - Only 12% receive 50 hours or more

Characteristics of Families Receiving Parent Training Services

- 36% of parents indicate that their children have behavior problems in the clinical or borderline range
- Whether the problems are with the children or the parents perception of the child does not really matter—this is still a barrier to success and can be changed with good parent training

But Does Parent Training Work?

- Tested parent training models for child conduct problems are very promising.
 - Changes in parenting behaviors
 - Reductions in child behavioral difficulties
 - Changes retained over time

Model Parent Training Programs

- Examples
 - Parent Child Interaction Therapy (PCIT)
 - The Incredible Years
 - Parent Management Training
 - Safe Care
- Have 30-year long shared roots in social learning theory

Model Parent Training Programs

Common features:

- Target specific parent skills identified as problematic through observational research
- Similar basic program components
 - Play
 - Praise and Rewards
 - Limit setting
 - Handling misbehavior

Model Parent Training Programs

Common features:

- Require completion of behaviorally specific homework each week
- Require frequent behavioral practice in session
- Methods for monitoring individual progress
- At least 15 hours (individual), 25 (group)
- Relatively intense supervision

Model Parent Training Programs

- Model programs beginning to be tested in child welfare
 - PCIT (Chaffin et al., 2004)
 - Usual parent training 49%
 - PCIT+ 37%
 - PCIT 19%
 - SafeCare (Chaffin et al., ongoing)
 - In progress, separating out contribution of supervision

Discussion

- Parent training is central to CWS:
 - family support
 - family preservation
 - family reunification and
 - post-adoption services
- Multivariate models indicate that parent training is given to families with the highest levels of need re: parenting skills
 - perception of risk to child
 - child behavior problems
 - cognitive stimulation at home

Discussion

- Model programs are not in use
- Amount of parent training received frequently lower than model programs
- Child welfare exercise of control over what parent training programs are used is not strong
 - Beggars can't be choosers

Conclusions

- Counties should evaluate the status of their own parent training programs serving families in child welfare, using model programs as reference points.
- In many counties, parent training services are likely an underdeveloped resource.
- Greater experimentation with model programs is strongly indicated.

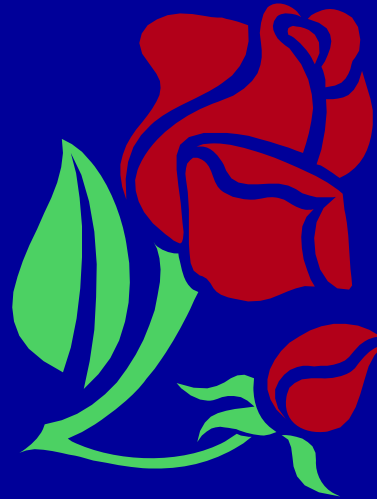
Policy: Parent Training Overlooked

- Promoting Safe and Stable Families (PSSF) provides no incentives to improve the *quality* of in-home services
- There is almost no research funding to test the application of evidence-based parenting programs in CWS
 - Funding of parenting program research should be routine and predictable so that this field can grow
- Building on existing non-CWS programs is strongly indicated

Policy: CFSR Redux

- Expectation of *evidence based* parent training
 - Components of effective parent training are present
- Expectation of developmentally appropriate parent training
 - Child welfare involved parents and children have very different needs according to child age

Thank you very much



Questions