Symposium:

Multi-site Findings from the Replication of a Family Strengthening Program with Diverse Populations to Prevent Child Maltreatment

IVIII ISPCAN International Congress: Strengthening Children and Families Affected by Personal, Intrapersonal, and Global Conflict
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Acknowledgements*

- 1996 -2009 Development & Demonstration of Family Connections
  - US DHHS Children's Bureau (90-CA1580)
    - Diane DePanfilis, PI (Howard Dubowitz & Esta Glazer-Semmel, Co-PIs)
  - US DHHS Children's Bureau (90-CW-1126)
    - Diane DePanfilis, PI (Clara Daining, Co-PI)
- Cross-site evaluation of replicating sites (2005-2010) (James Bell Associates)
  - US DHHS Children's Bureau (GS10F0204K)

Purpose of this Symposium

- The purpose of this symposium is to report on the results of a cross-site evaluation to evaluate adaptations made to Family Connections to be culturally responsive to different target populations
  - To assess the fidelity of replication
  - To evaluate change over time by varied ethnic groups in intermediate outcomes (protective and risk factors)
  - To evaluate the degree to which programs were successful in preventing child maltreatment among diverse client groups as measured by reports to Child Protective Services (CPS) agencies.

Symposium Objectives

- As a result of this session, participants will understand:
  - (1) how programs tailored Family Connections to families from different cultural groups and the degree to which these adaptations met program fidelity criteria;
  - (2) how protective and risk factors changed over time; and
  - (3) the complexities of measuring the prevention of child maltreatment through official reports to Child Protective Services (CPS) agencies.

Three Papers

- Paper 1: Paper 1: Cultural Adaptations and Assessment of Fidelity
  (Jill H. Filene, Diane DePanfilis, & Elliott G. Smith)
- Paper 2: Assessing intermediate outcomes: Increasing protective factors and decreasing risk factors with ethnically diverse families
  (Elliott G. Smith, Jill H. Filene, & Diane DePanfilis)
- Paper 3: Assessing final outcomes: Comparing differences in CPS reports by Ethnically Diverse Client Families
  (Diane DePanfilis, Elliott G. Smith, & Jill H. Filene)

Paper Acknowledgements

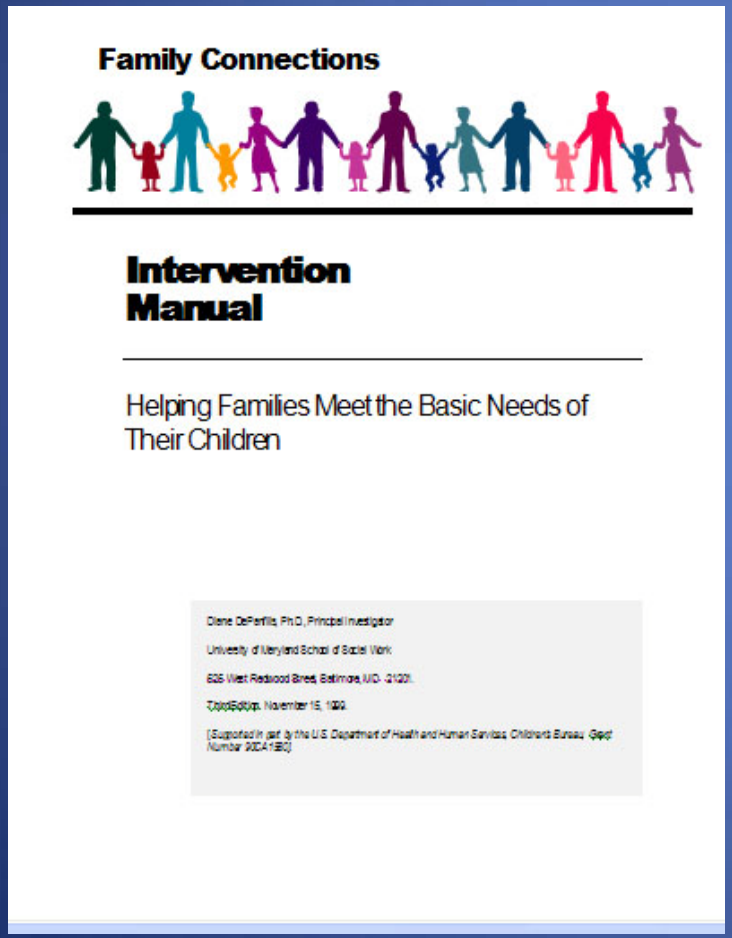
- Lauren Kass (James Bell Associates)
  – contributed to Paper 1

- Karen Rice (University of Maryland)
  – contributed analysis to Paper 3

Background – Family Connections

- Family Connections was developed in 1996 to:
  - reduce risk factors associated with neglect and
  - enhance protective factors that may help families more adequately meet the basic needs of their children resulting in improved outcomes for their children.

Intervention Manual

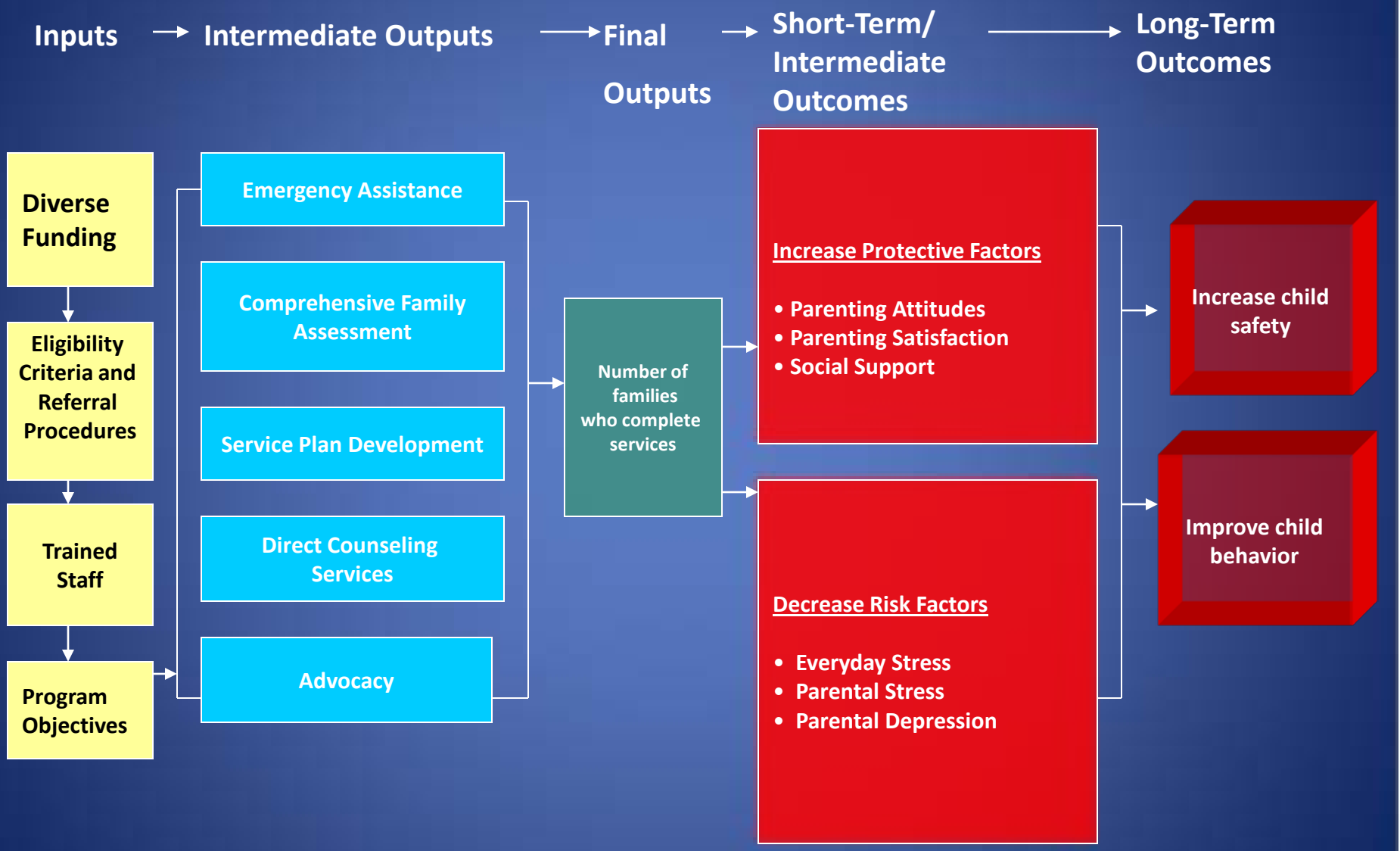


- Specifies
  - Theory
  - Practice Principles
  - Social Work Process (outreach, engagement, assessment, planning, tailored outcome driven case plans, intervention strategies, methods for evaluating change).

Philosophical Principles

- Ecological developmental framework
- Community outreach
- Family assessment & tailored intervention
- Helping alliance with family
- Empowerment/strengths based
- Cultural competence
- Outcome-driven service plans

Original Logic Model - Family Connections



Prior & Current Research

- Original demonstration (1996-2002) (DePanfilis, Dubowitz, & Glazer – Semmel)
  - Published papers:
    - *Child Maltreatment* (DePanfilis & Dubowitz, 2005)
    - *Research on Social Work Practice* (Girvin, DePanfilis, & Daining, 2007)
    - *Child Abuse & Neglect* (DePanfilis, Dubowitz, & Kunz, 2008)
    - *Research on Social Work Practice* (Lindsay, Hayward, & DePanfilis, in press)

- Dissertation - An exploration of social support and coping and the impact on caregiver well-being among African American grandmothers who provide care for their grandchildren. (Simpson, 2003)
- Dissertation – Neighborhood conditions, father involvement, parenting competence, and behavior problems in a sample of children at risk for neglect: A structural equation model (Hayward, 2009)
- Testing trauma adapted Family Connections (2007-2012) (Collins, DePanfilis, & Strieder)

Limitations of Initial Evaluation

- Relatively small sample
- Some questions about fidelity of intervention (despite intervention manual)
- Short follow-up (only 6 months)
- No control group

Replication of Family Connections

- *Emerging Practices in the Prevention of Child Abuse & Neglect* (2003)
  - Funding announcement for Replications of Demonstrated Effective Prevention Programs (2003)
- Funding by the USDHHS, Children's Bureau, Office of Child Abuse and Neglect to 8 organizations to replicate Family Connections (2003-2008)

FC Replication Projects

- Youth Health Service, Inc., Elkins, WV
  - Rural families living in Randolph and Barbour counties, West Virginia
- University of Maryland School of Social Work, Baltimore, MD
  - Intergenerational families at-risk for neglect living in Baltimore.
- Child and Family Tennessee, Knoxville, TN
  - At-risk families living within the Knoxville Empowerment Zone.

FC Replication Projects

- Black Family Development, Inc., Detroit, MI
  - Families living in high-risk communities of Detroit and Highland Park, MI.
- DePelchin Children's Center, Houston, TX
  - Families with children 5-14 years old attending selected schools in Dickinson, Texas.
- Respite Care of San Antonio, Inc., San Antonio, TX
  - Families with children with disabilities living in San Antonio, Texas

FC Replication Projects

- Asian Pacific Counseling & Treatment Center, Los Angeles, CA
  - At-risk Cambodian and Korean families living in Los Angeles.
- Children's Institute Incorporated, Los Angeles, CA
  - High-risk families with children birth to three years old living in South Central Los Angeles.

Objectives: Cross-Site Evaluation

- To what extent are the projects able to implement *FC* with fidelity?
- To what extent are the projects able to demonstrate positive outcomes in reducing the risk factors and increasing protective factors for child neglect that were found in the original *FC* Demonstration Project?
- To what extent are projects able to prevent child maltreatment?

Additional Objectives: Cross-Site Evaluation

(not addressed today)

- To what extent have the projects made adaptations to *FC* and what is the impact of those changes?
- What are the costs associated with implementing *FC*?

Paper 1: Cultural Adaptations and Assessment of Fidelity

Jill H. Filene
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University of Maryland, Baltimore

Elliott G. Smith
Cornell University

Process of Replication of FC

- Program Installation
  - The program follows steps for developing an implementation plan which includes revising the FC intervention manual for their target population
    - They submit these documents for review and acceptance prior to implementation
  - Core training is provided to key personnel (this is as close to their implementation start date as possible).
  - In the implementation plan and MOU, there is agreement about how fidelity will be self-evaluated and assessed by the RYC.
  - Once fidelity assessments are employed, ongoing training and technical assistance is provided to enhance fidelity

Adaptation

- Premises
  - Adaptation must consider ethnicity and culture of clients
  - Cultural/ethnic adaption is not enough
    - Service contexts determine what adaptation is needed and how much

Zayas, 2010

Multiple Services Context

- Service Sector (e.g., community based organization, child welfare, mental health)
- Region & Geography (e.g., country, part of the country, rural/urban, suburban)
- Organizations & Institutions (e.g, Government, private, multi-service organization)
- Clients, consumers (e.g., culture, age, immigrant, legal status)

Zayas, 2010

Types of Adaptation

- Adaptation (broad term – adjustments and modifications)
- Targeting (adaptation of service at the population, community, and organizational levels)
  - Use of a Community Advisory Committee
- Tailoring (Adaptation of intervention at the family level)
  - Clinical tailoring: unique constellation of issues brought by individual families

Zayas, 2010

Importance of understanding the unique needs of the target population

- Values about accepting help (issues of privacy, decision-making)
- Experience with other help giving systems
- Issues of acceptance of someone in the role of helper
- Need to modify or tailor efforts for engaging, motivating, and supporting the target recipients.

Wu, et. al, 2009

Cultural Competence

- Ability to understand, to the best of one's ability, the worldview of our culturally different clients and adapt our practice accordingly.
- In order to best meet the needs of families, the helper must understand the world from the client's point of view and provide needed help in a manner in which it can be used.

Abney, 2001

Guiding Principle of Replication

- Cultural competence:

It is important that interventions respect an understanding that culture can play a protective role . . .and it is important that you seek from the family, *their* definition of who should be involved in particular assessments, interventions, and planning activities, rather than making assumptions about, who is "family" or who forms "community" for this child and family.

Training Builds Competence

- To tailor the intervention to respect the unique needs and strengths of target families
  - Engagement, assessment, and selecting of change focused interventions

Background: Implementation Fidelity

- Fidelity: the extent to which the delivery of an intervention adheres to the protocol or program model as intended by the developers of the intervention (Mowbray, Holter, Teague, & Bybee, 2003)
- The assessment of fidelity is particularly important when programs are implemented in "real world" settings where program drift is common (Duesnbury, Branningan, Falco, & Hansen, 2003)

Background: Implementation Fidelity

- Main purposes for collecting fidelity data:
  - Understand program implementation
  - Examine theoretical assumptions
  - Interpret outcome findings
  - Provide feedback for continuous quality improvement
  - Provide feedback to developers about the program

(Backer, 2001; Dane & Schneider, 1998; Domitrovich & Greenberg, 2000; Mowbray, et al., 2003)

Study Question

To what extent do *FC* replication sites adapt FC to be culturally congruent with their target populations and implement *FC* with fidelity?

Methods: Development of *FC* Cross-Site Fidelity Assessment

- Identification of and agreement on *FC* cross-site fidelity criteria categories:
  - Philosophical principles (9)
  - Program structure (14)
  - Administrative activities (5)
  - Professional development activities (5)
  - Research activities (6)
- Operationalize *FC* fidelity criteria

Methods: Development of *FC* Cross-Site Fidelity Assessment

Philosophical Principles

- Community outreach
- Individualized, tailored intervention
- Helping alliance
- Strengths perspective
- Empowerment approach
- Developmental appropriateness
- Cultural Competence
- Advocacy

Program Structure

- Services in home/community
- Utilize community advisory panel
- Implement marketing/recruitment proc.
- Manage referrals
- Comprehensive Family Assessment**
- Develop and match SMART goals to assmt.
- Face-to-face contact w/in 1 business day
- One hour face-to-face contact per week
- Provide emergency services as needed

Professional Development

- Provide initial and ongoing training
- Provide weekly clinical supervision
- Provide professional devel. opportunities
- Foster an organizational culture

Administrative Activities

- Establish safety policies
- Implement risk management procedures
- Implement methods for assuring quality

Methods: Development of *FC* Cross-Site Fidelity Assessment

- Archival data abstraction
  - Implementation Plan
  - Semi-Annual Report Narrative
  - Semi-Annual Fidelity Database
  - Final Report
- Case record review
- Semi-structured interviews
- Focus groups

Methods: Development of *FC* Cross-Site Fidelity Assessment

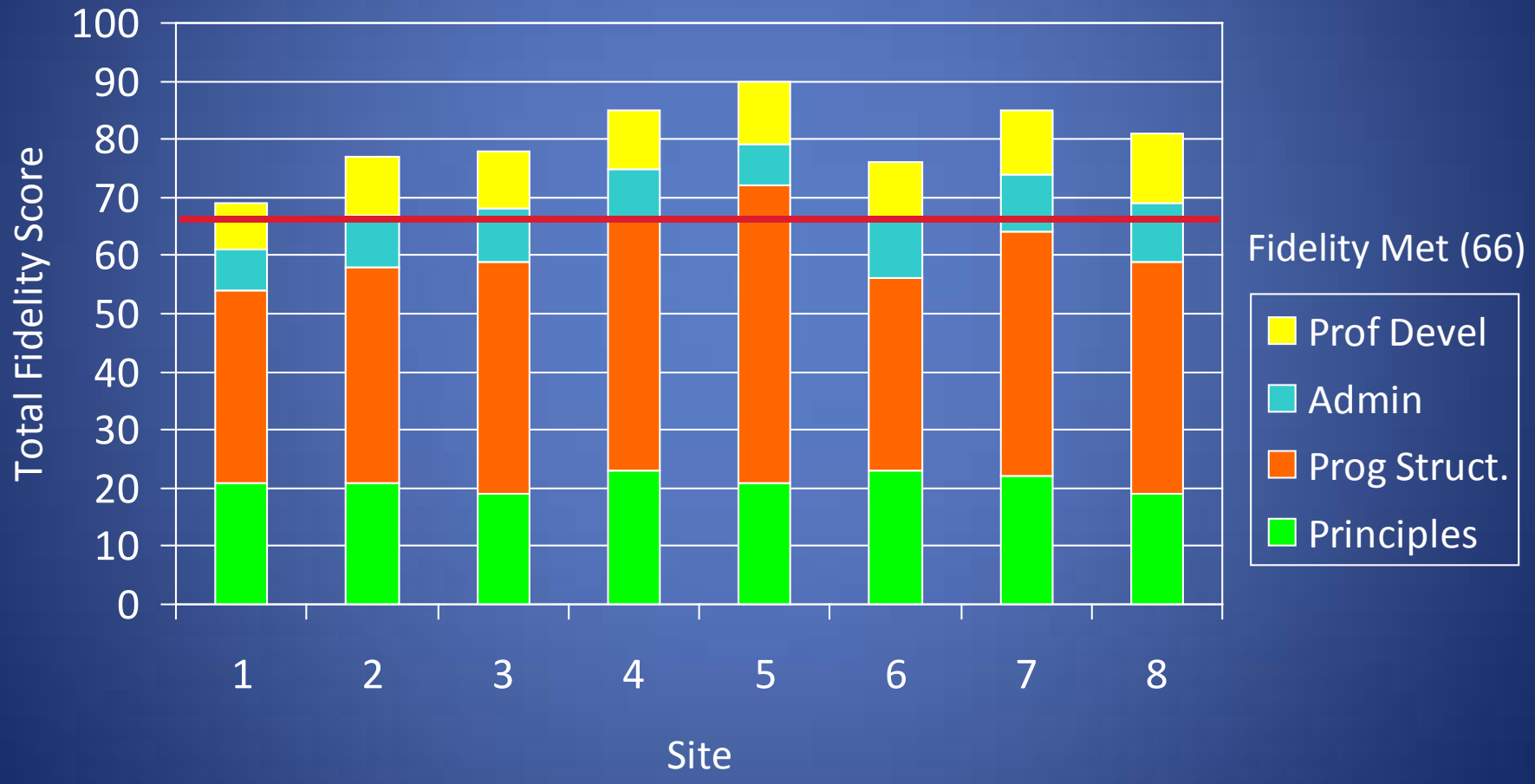
- Fidelity Assessment Framework
  - 33 items
  - 5-point likert scale
    - 0 = Not implemented/concerning
    - 1 = Below Standard
    - 2 = Standard Met
    - 3 = Above standard
    - 4 = Exceptional
  - Scored at site- and staff-levels (when applicable)

Snapshot of Results:

Initial Comprehensive Family Assessment (CFA)

Total Fidelity Score by Site

(Range 0-122)

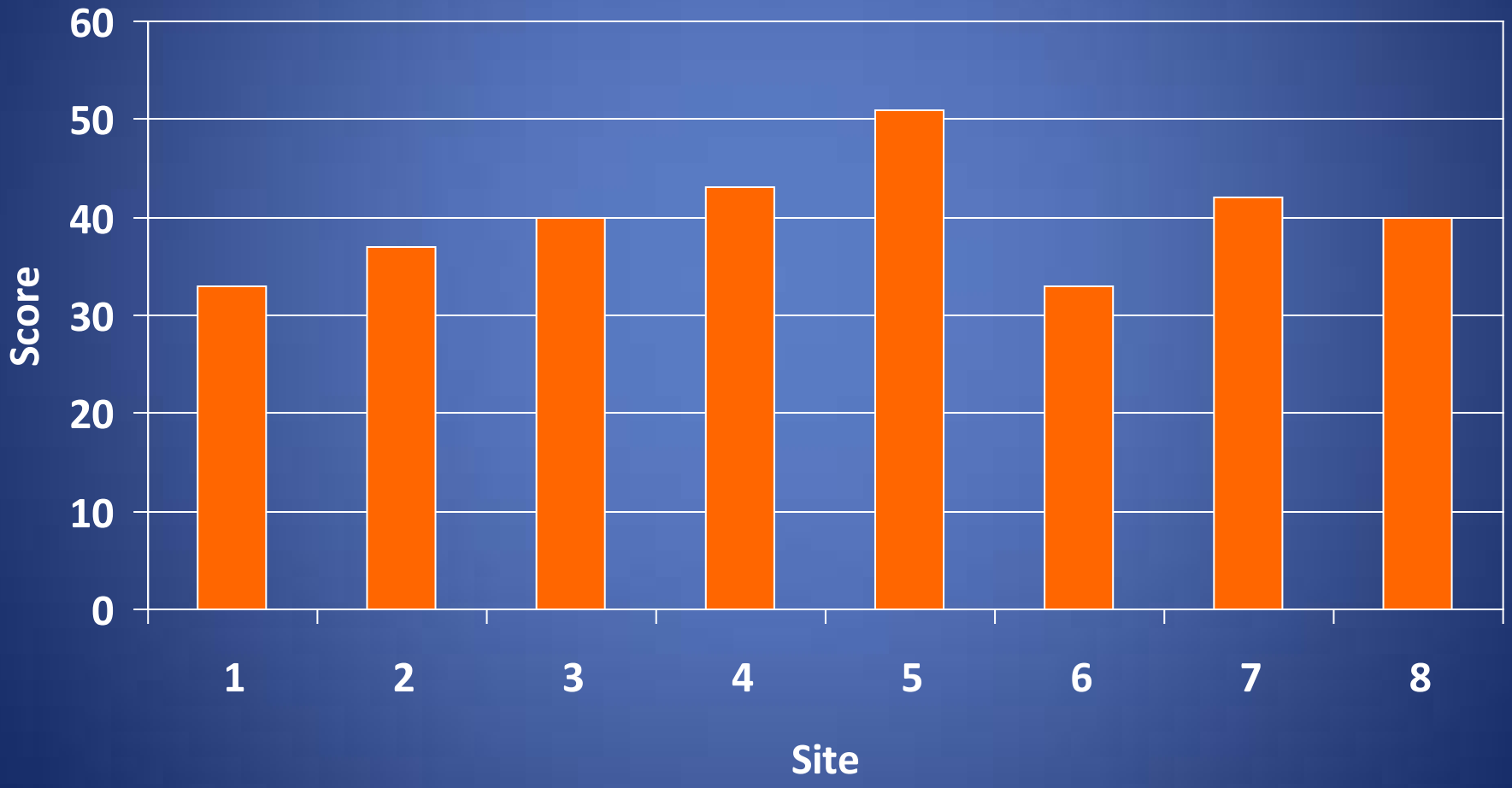


Total Fidelity Score by Site

(Range 0-122)

Philosophical Principles

Program Structure



Administrative Activities

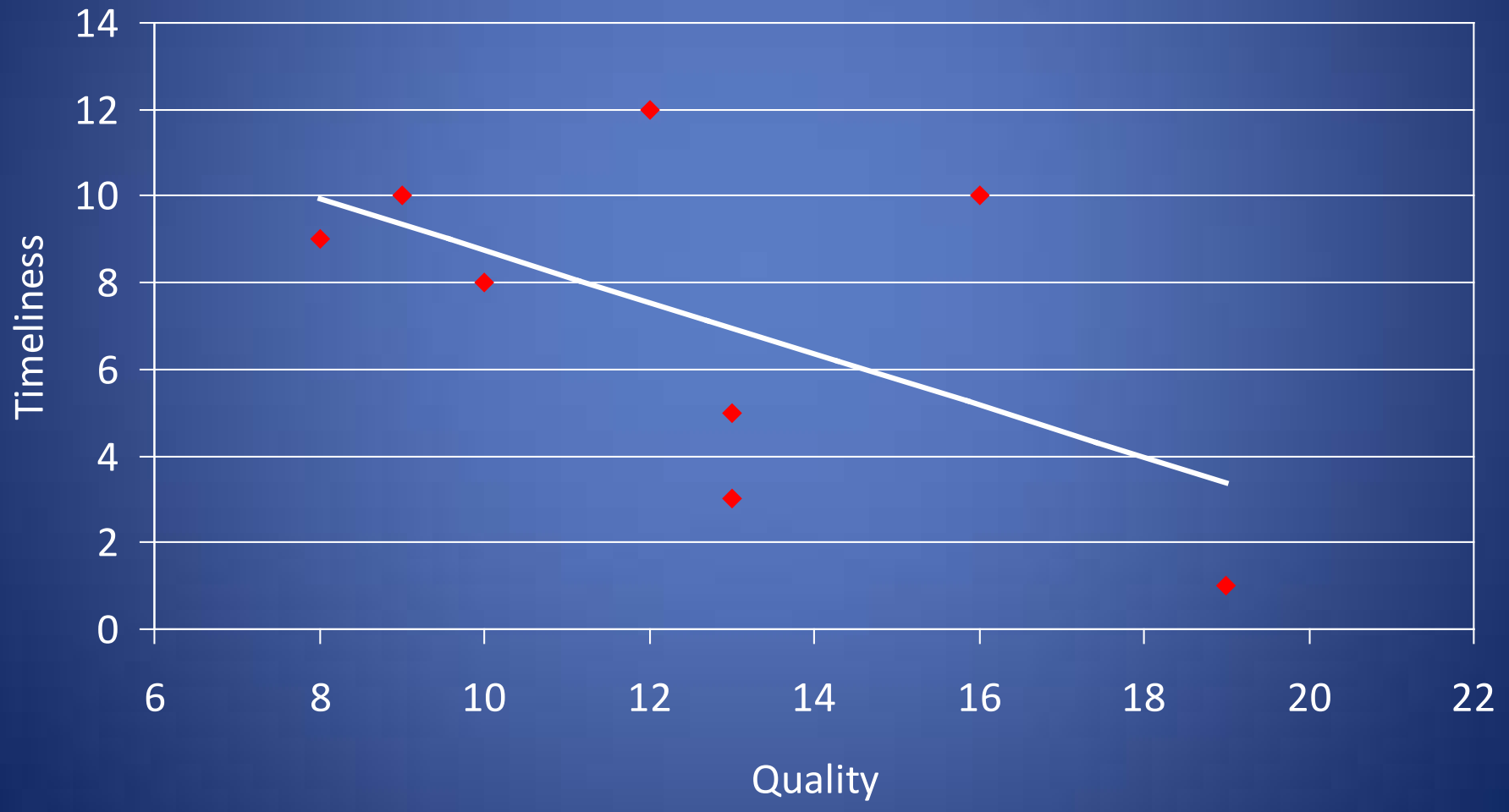
Professional Development

Comprehensive Family Assessment

- Comprehensiveness/Quality
  - Use clinical assessment instruments
  - Examine multiple domains
  - Provide narrative of scores & assessments
  - Develop tentative/formative assessment
  - Identify strengths
- Timeliness
  - Conduct initial assessment within 30 days of intake
  - Review/reassessment at 3-month intervals
  - Reassessment prior to case closure

Comprehensive Family Assessment

Comprehensive Family Assessment



Limitations of Fidelity Assessment

- Cross-site evaluation funded Year 3
- Direct observation of implementation not feasible
- Majority of fidelity data at staff/site level, not participant level

Discussions/Implications

- Overall, sites implemented *FC* with fidelity
- Cultural adaptations of *FC*
  - Site description of culture (e.g., Cambodian immigrants vs. CSHCN)
  - Intentional (planned) adaptation?
    - Adherence to criteria
    - Characteristics of service delivery

Clarifying Questions

Paper 2
Assessing outcomes: Increasing protective factors and decreasing risk factors with ethnically diverse families

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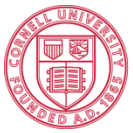

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Study Questions

- How much did families in the study improve over time?
- Did *Family Connections* families improve more than typical services families?
- Did assigned service duration of *Family Connections* matter in terms of outcomes?
- Did fidelity to the *Family Connections m*odel moderate improvements in outcomes?

Method

- Eight replication sites
- Random assignment to condition
- Focus on the primary caregiver and an index child from each family
- Assessments at Baseline, service completion (Post-Test), and 6 month Follow-Up

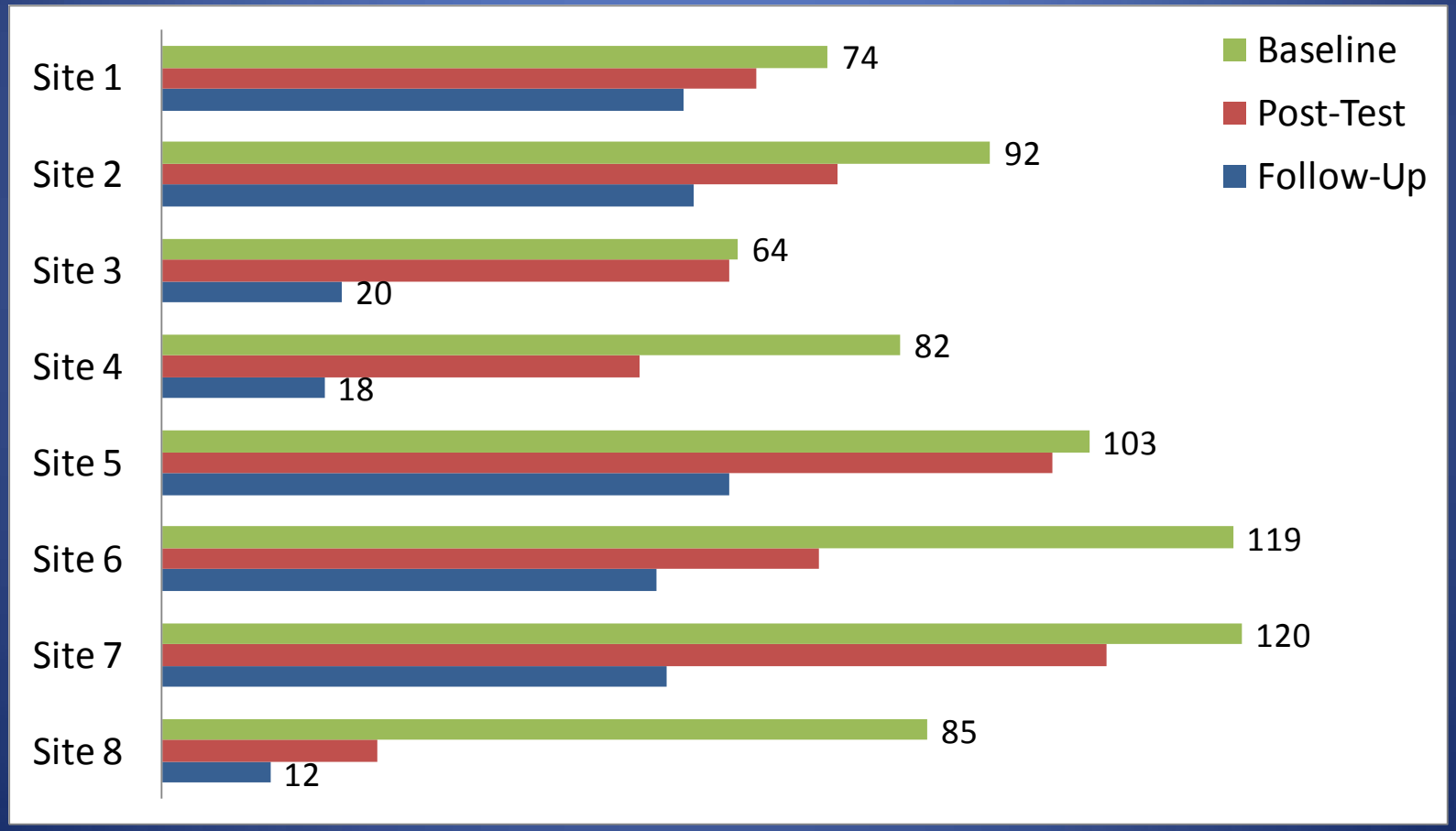
Study Conditions

Site	Condition	Service Duration	Treatment	Dose
4	No FC	Information and referral		
	Yes FC	9 mo		
6	No FC	Services as usual		
	Shorter FC	6 mo		
	Longer FC	12 mo		
7	No FC	Information and referral		
	Shorter FC	3 mo		
	Longer FC	6 mo		
1	Shorter FC	3 mo		
	Longer FC	6 mo		
2	Shorter FC	3 mo		
	Longer FC	6 mo		
5	Shorter FC	3 mo		
	Longer FC	6 mo		
3	Shorter FC	3 mo		
	Longer FC	9 mo		
8	Shorter FC	6 mo		
	Longer FC	12 mo		

Participating Families

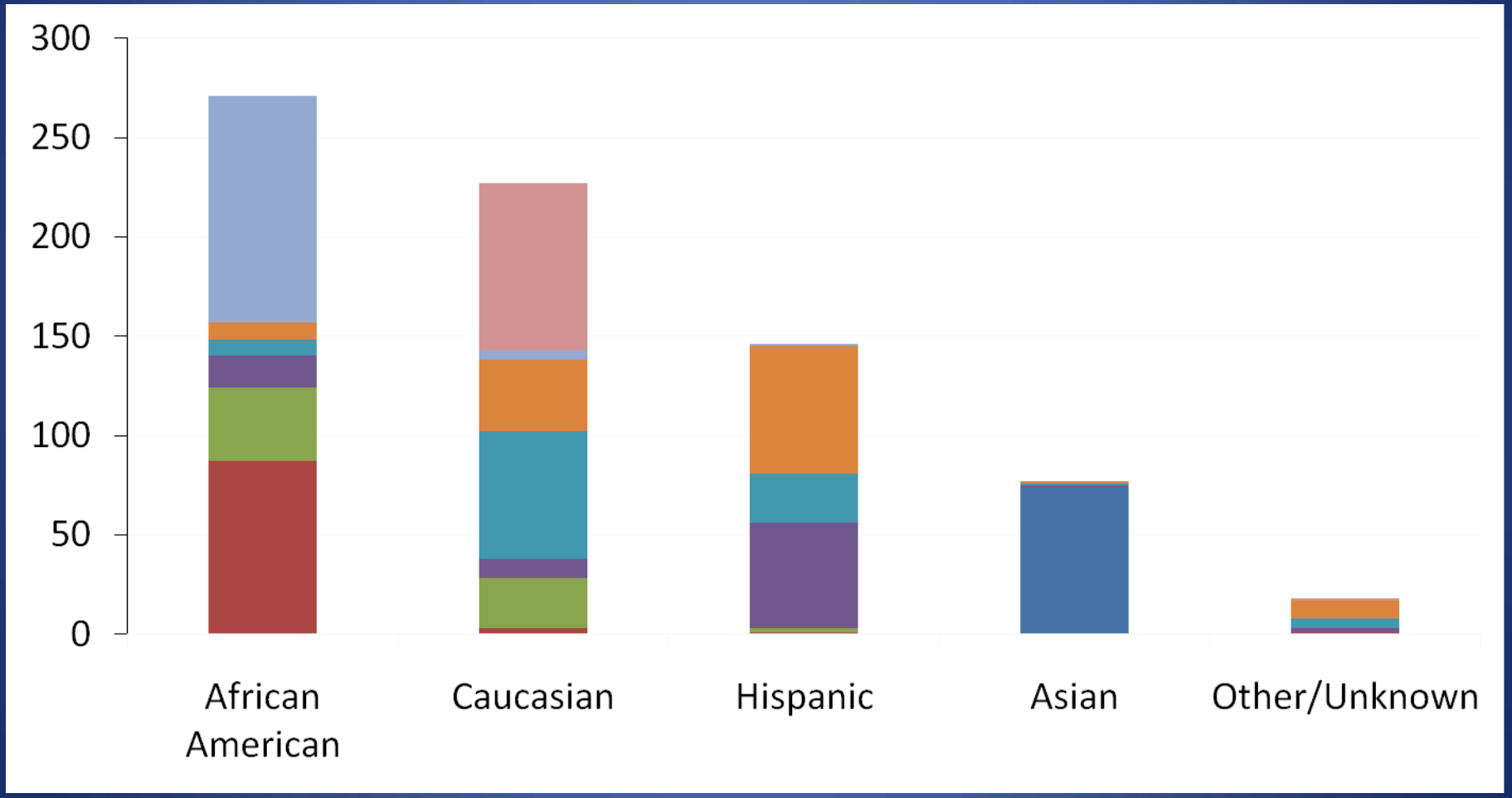
775 assigned to condition

95% (n=739) with usable outcome data at Baseline



Diverse Case Mix Varied Across Sites

(n = 739 caregivers)



Risk Factors for Maltreatment

- **Family Functioning**
  - **FAF**: Family Assessment Form (Baseline & Post-Test) (Children's Bureau of Southern California, 1997)
  - Count of items with higher ratings (3 to 5). Range is 0 to 98.
- **Caregiver Depressive Symptoms**
  - **CES-D**: Center for Epidemiologic Studies Depression Scale (Radloff, 1997)
  - Scores > 16 indicate depression. Range is 0 to 60.
- **Caregiver Stress**
  - **PSI**: Parenting Stress Index – Short Form (Abidin, 1995)
  - Scores > 90 are clinically significant. Range is 36 to 180.

Protective Factors for Maltreatment

- **Need for Support**
  - **SFS**: Support Functions Scale (Dunst, Trivette, & Deal, 1988)
  - Scores > 36 indicate Moderate or Extensive Need. Range is 20 to 100.
- **Parenting Attitudes**
  - **AAPI**: Adult-Adolescent Parenting Inventory – 2 (Form A) (Bavolek & Keene, 1999)
  - Subscale Scores < 4 indicate high risk. Range is 1 to 10.
    - Appropriate Expectations
    - Level of Empathy
    - Resist Corporal Punishment
    - Family Roles
    - Power-Independence

Child Behavior

- **Externalizing Problem Behavior**
- **Internalizing Problem Behavior**
  - **CBCL**: ASEBA Child Behavior Checklist (Achenbach, 1991)
  - Scores > 63 are clinically significant.
  - Scores 60-63 are borderline
  - Range is 0 to 100.

Analysis

- 3 Level Linear Mixed Model using the SPSS Mixed Procedure
- Clustered longitudinal data with families nested in sites and time nested in families

Control Variables

Covariates were kept in a model if they were significantly related to the outcome

- Child sex
- Child age
- Child race/ethnicity
- Caregiver age
- Caregiver is a parent or a non-parent
- Caregiver marital status
- Caregiver highest grade completed
- Caregiver working for pay
- Number of adults in the household
- Number of children in the household
- Annual household income

HOW MUCH DID FAMILIES IMPROVE OVER TIME?

Time Model

n=654 families

Site 8 was excluded due to severe lack of Post-Test and Follow-Up data.

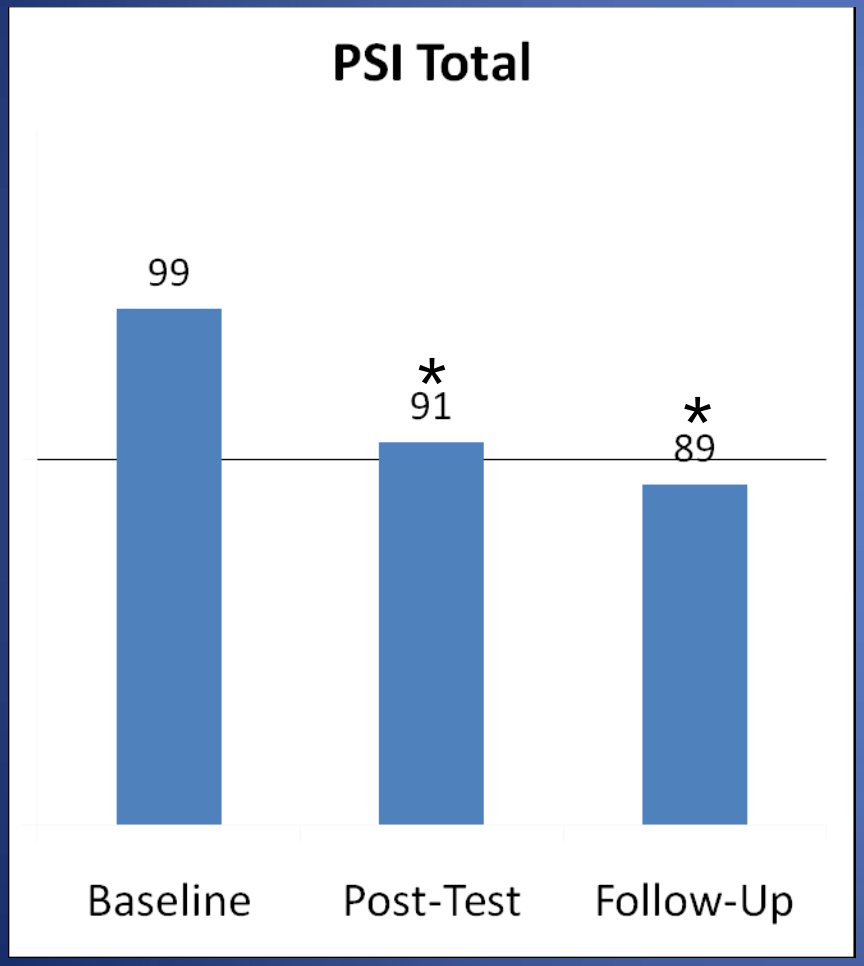
Fixed Effects

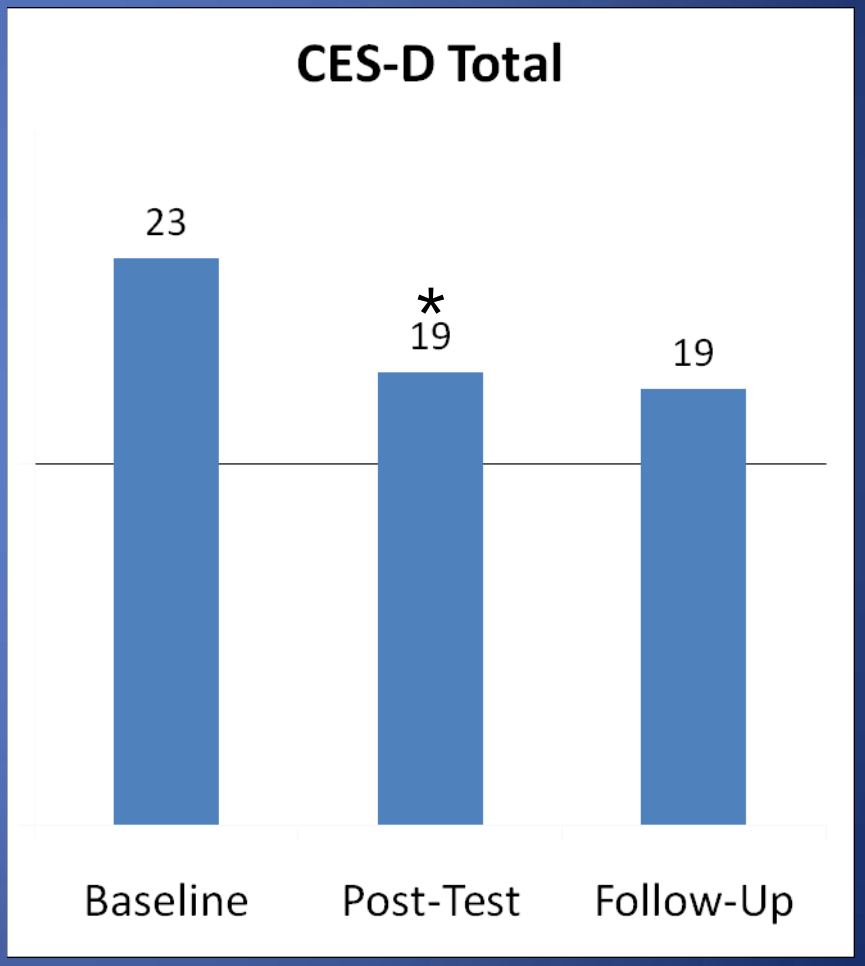
- Time (Baseline, Post-Test, Follow-Up)
- Significant control variables

Repeated Effects

- Time | subject=Site*FamilyID using an unstructured covariance matrix

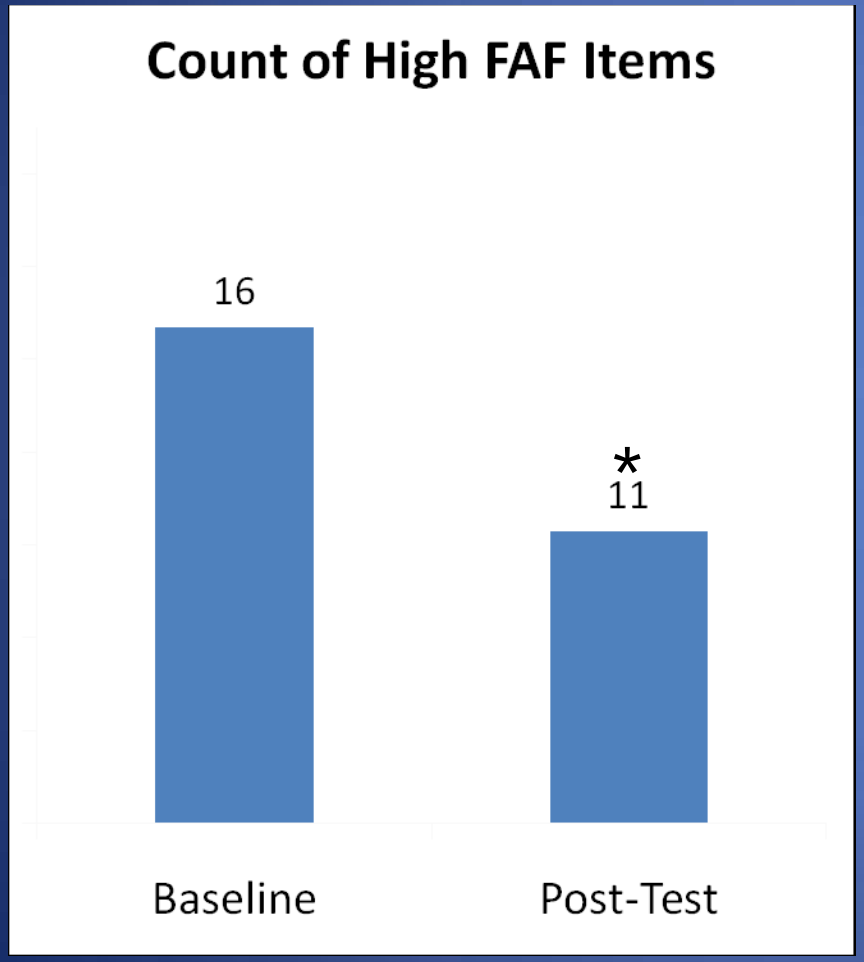
Parental Stress and Depression

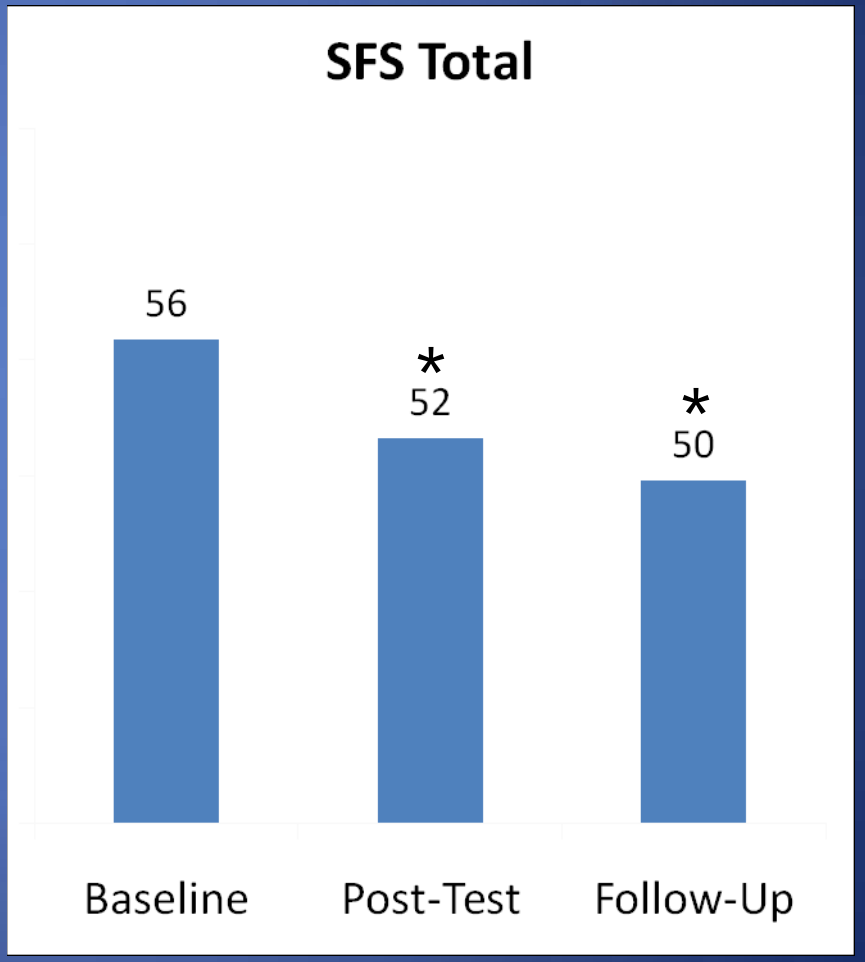




* Significant difference from preceding time point at $p < .05$

High FAF and Need for Support





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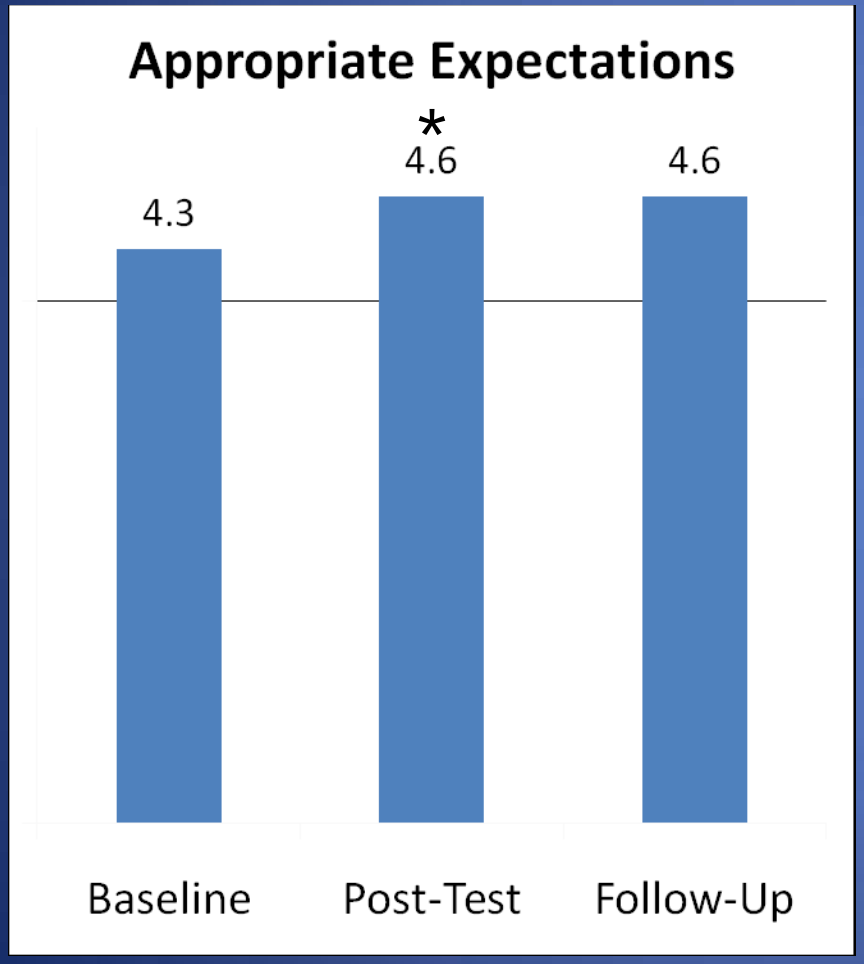
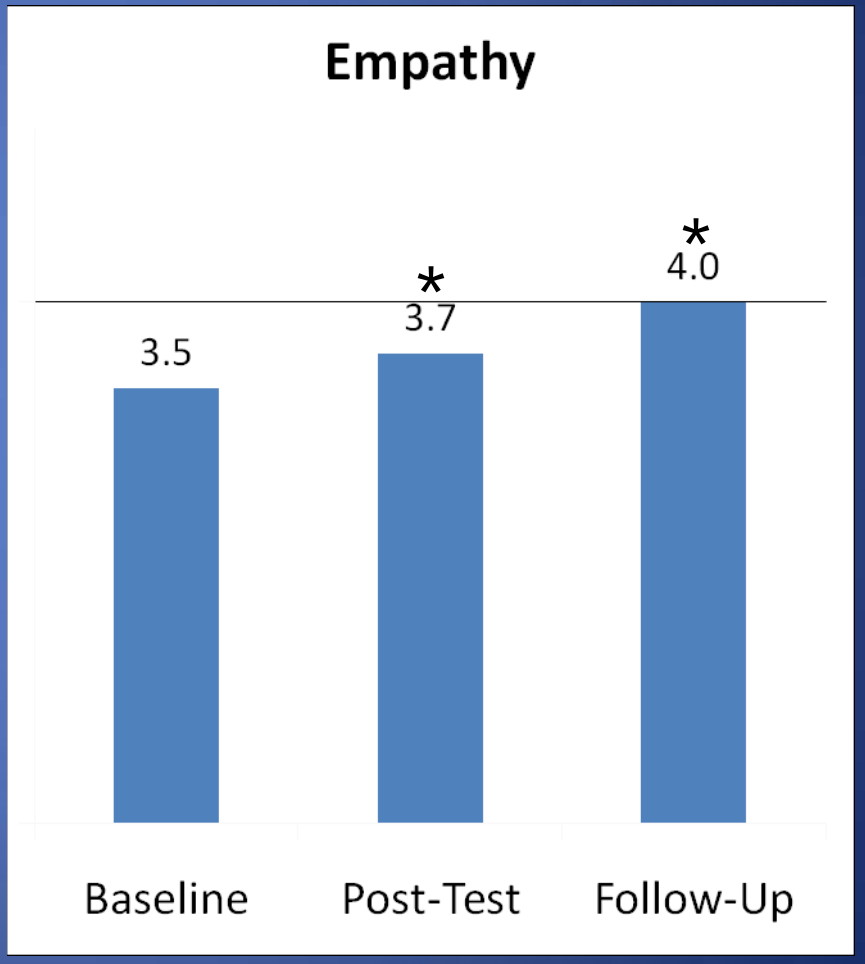
Adult-Adolescent Parenting Inventory





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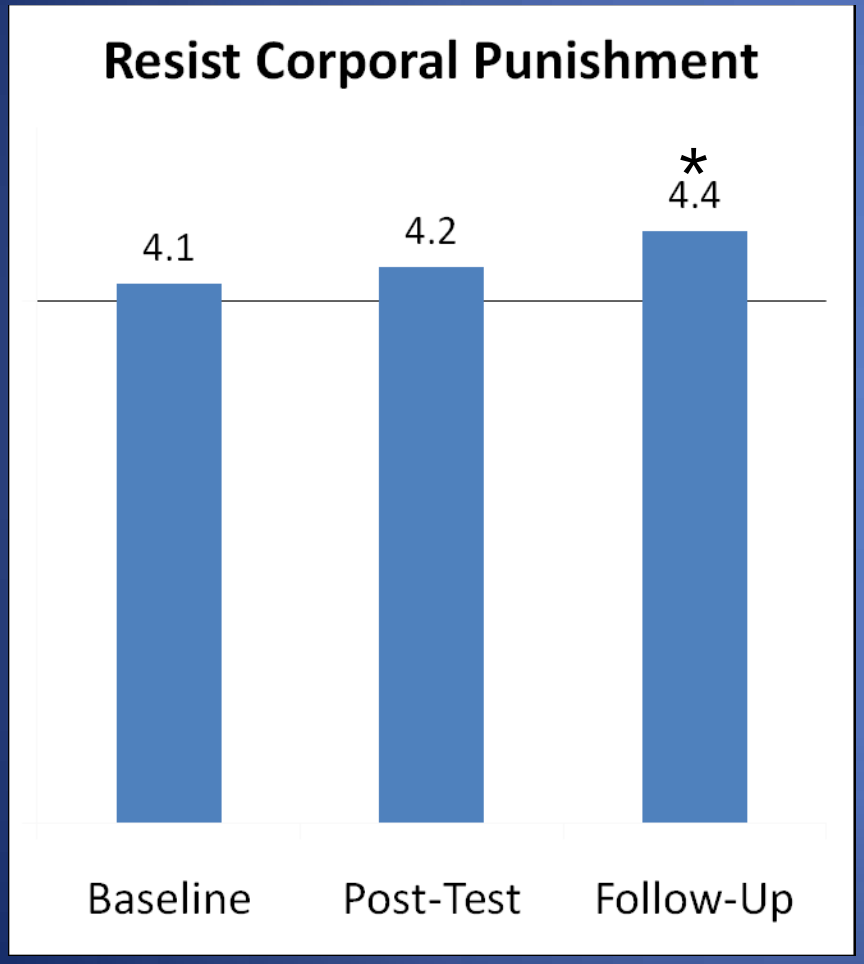

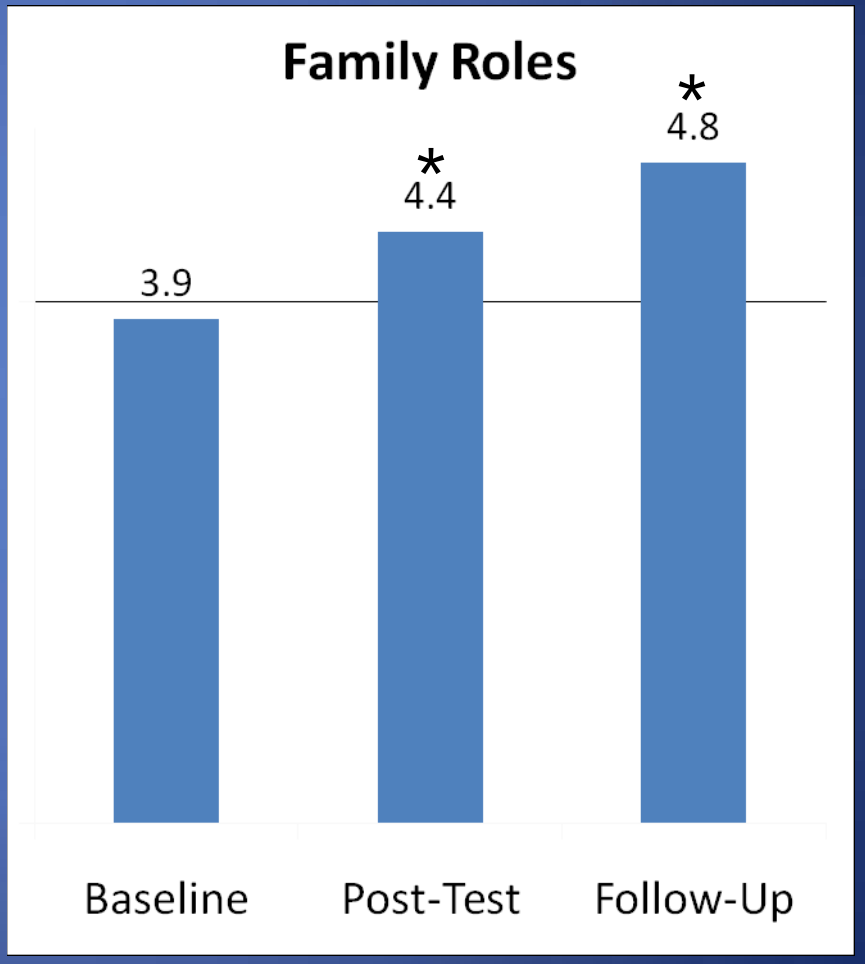

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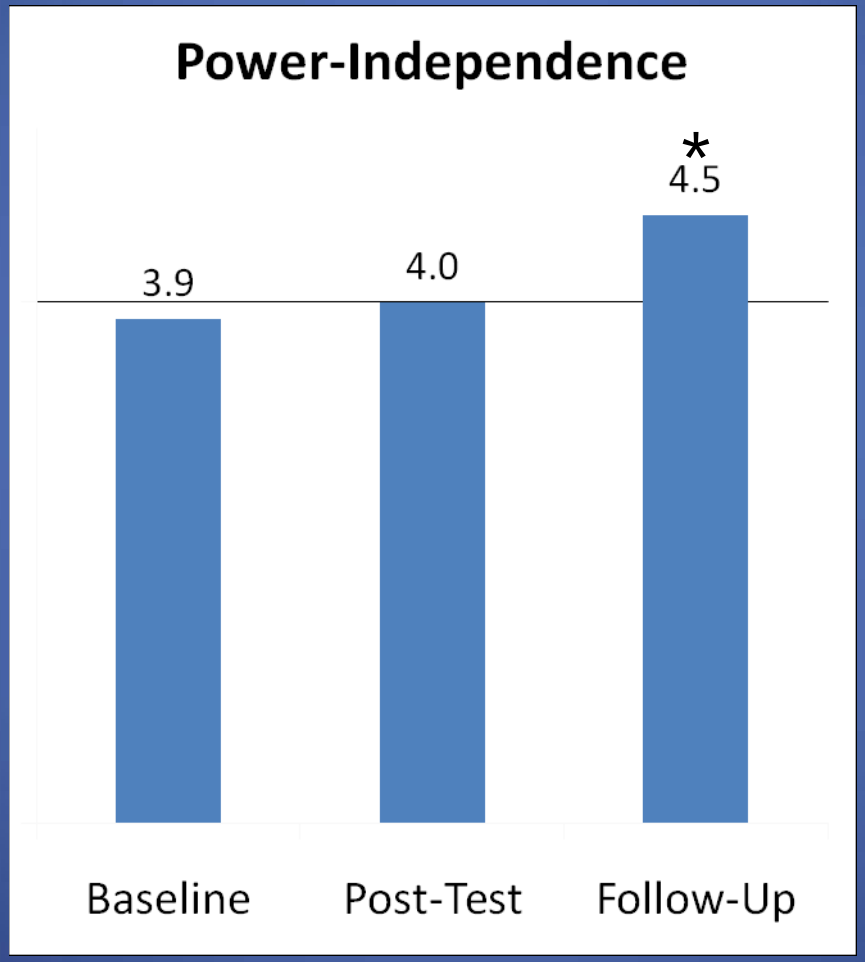

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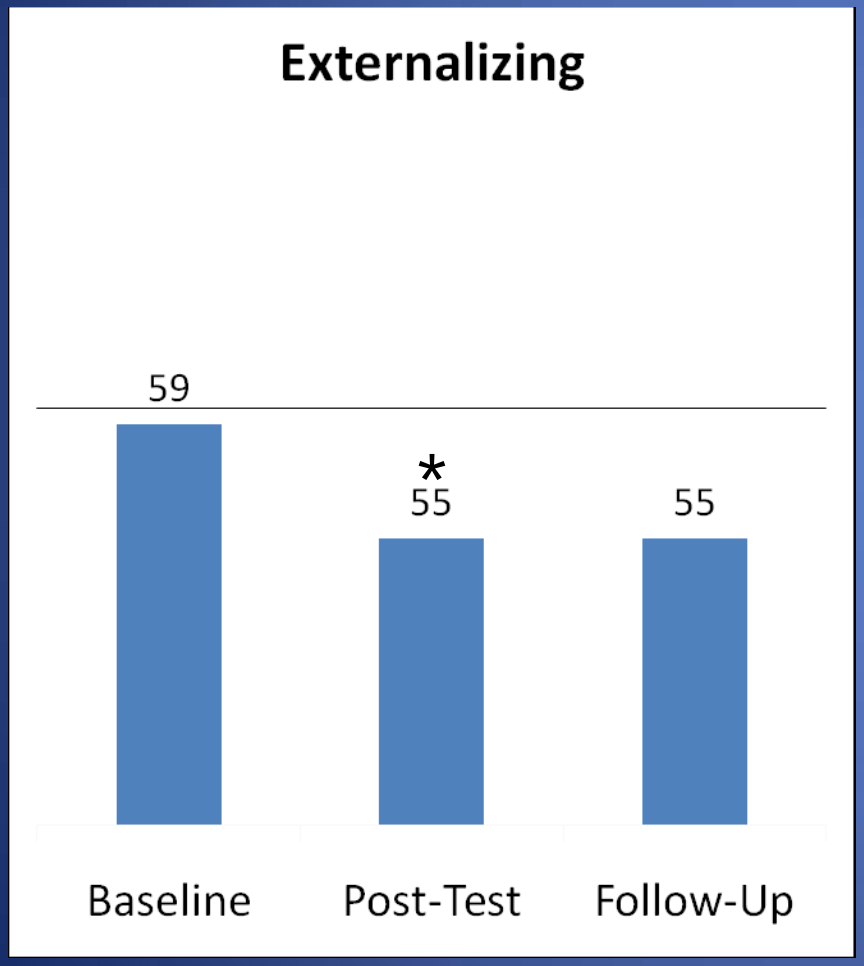
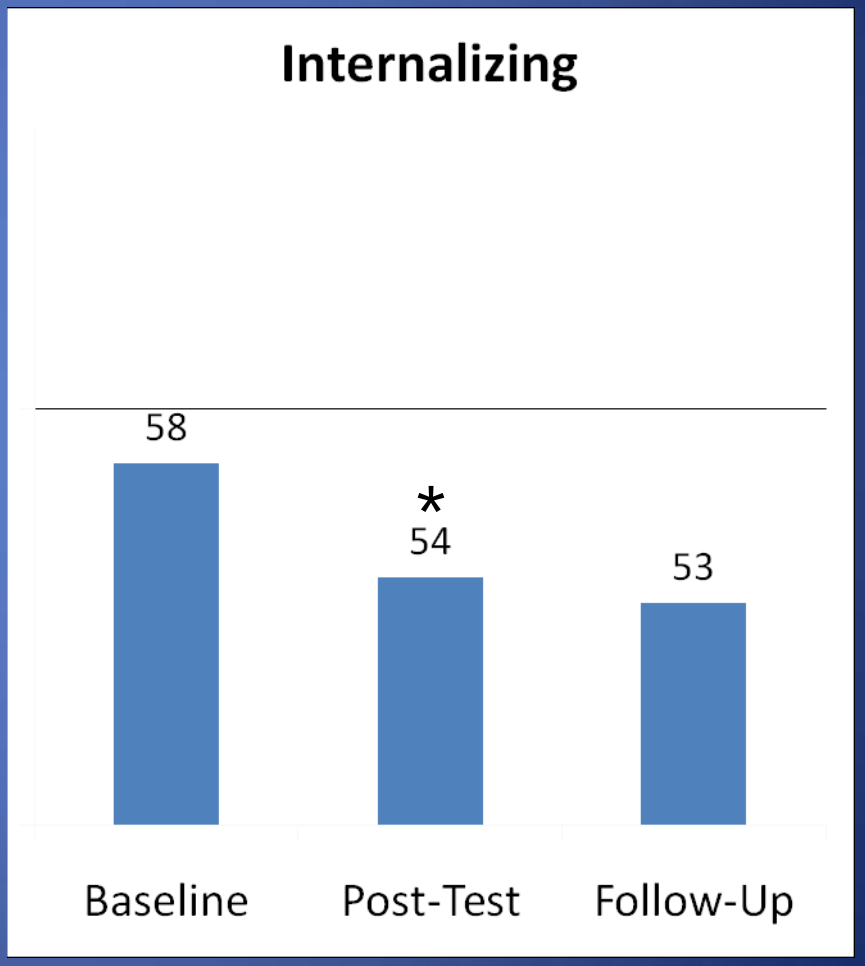
Child Behavior Checklist





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Summary: How much did families improve?

- Statistically significant improvements were found in all outcomes and ranged from 0.2 to 0.5 of a standard deviation.
- Parental Stress and High FAF improved the most. AAPI Corporal Punishment and AAPI Expectations improved the least.
- Despite improvements, at the 6 month follow-up, families continued, on average, to be in the clinical range on depressive symptoms and to have many areas of family functioning in need of attention.

DID *FAMILY CONNECTIONS* FAMILIES IMPROVE MORE THAN TYPICAL SERVICES FAMILIES?

Treatment Model

n=321 families

Sites 4, 6, 7 included. Follow-up data for Site 4 Treatment were dropped because there was no corresponding comparison group

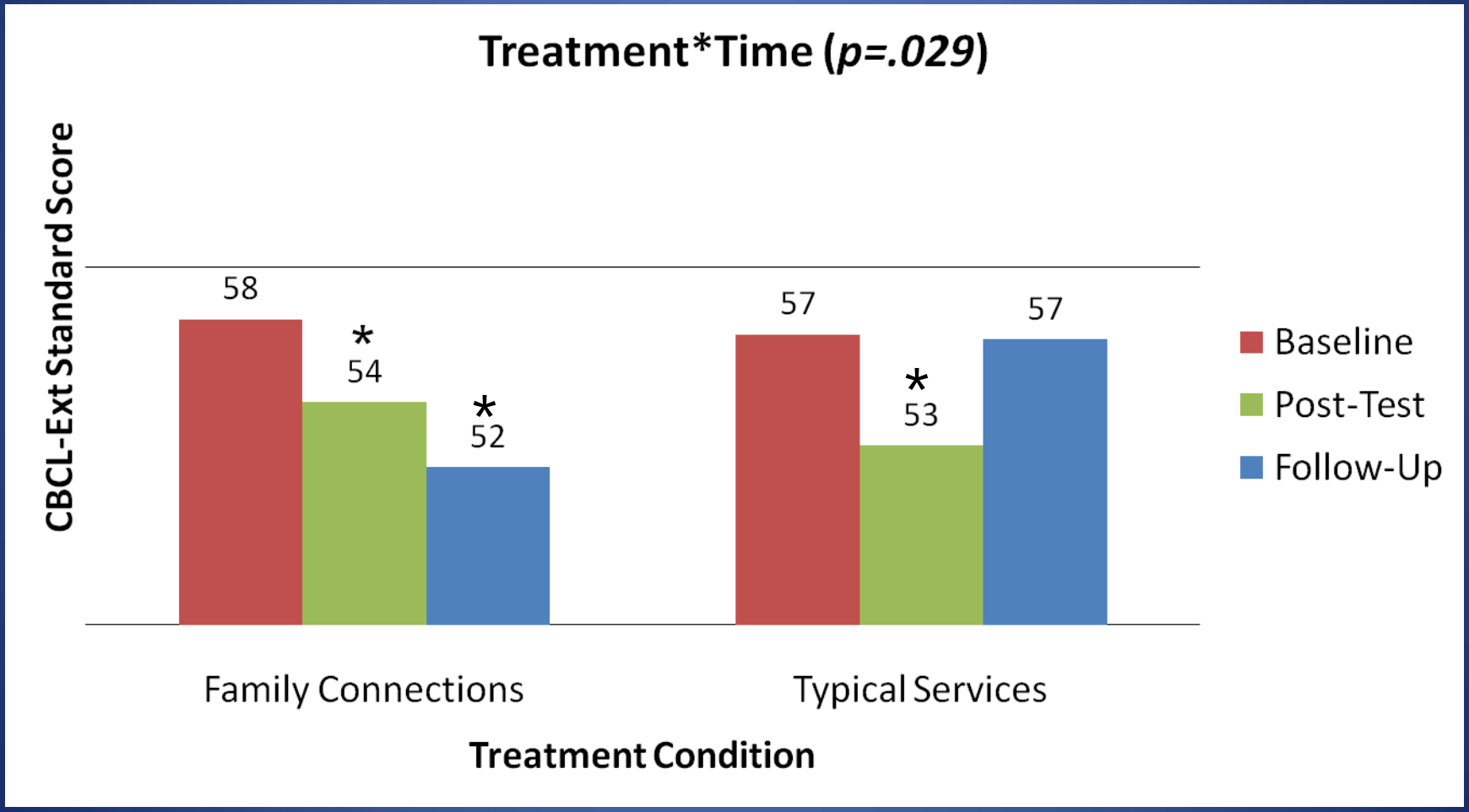
Fixed Effects

- Treatment (*Family Connections* vs. Typical Service)
- Time (Baseline, Post-Test, Follow-Up)
- Significant control variables

Repeated Effects

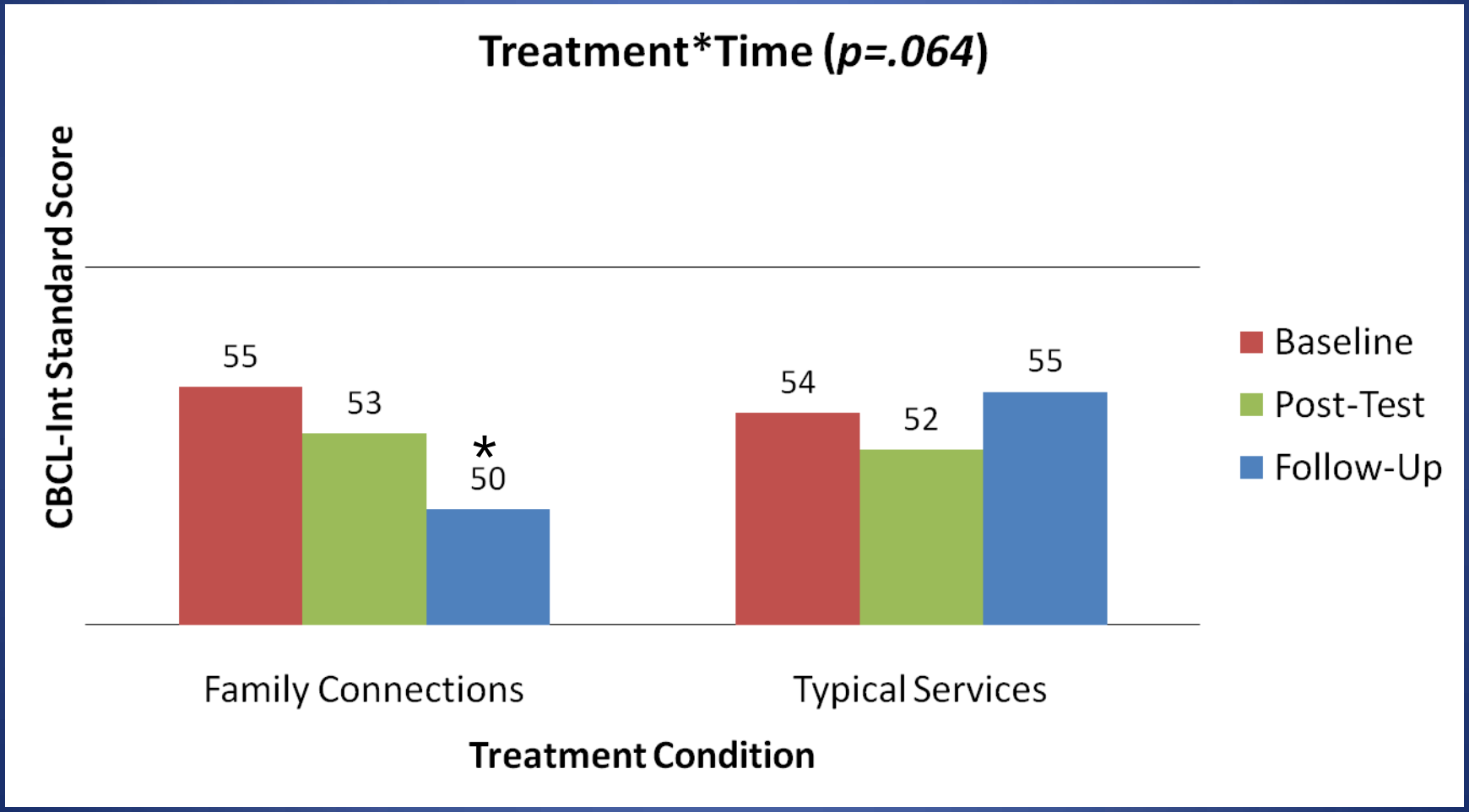
- Time | subject=Site*FamilyID using an unstructured covariance matrix

Child Behavior-Externalizing



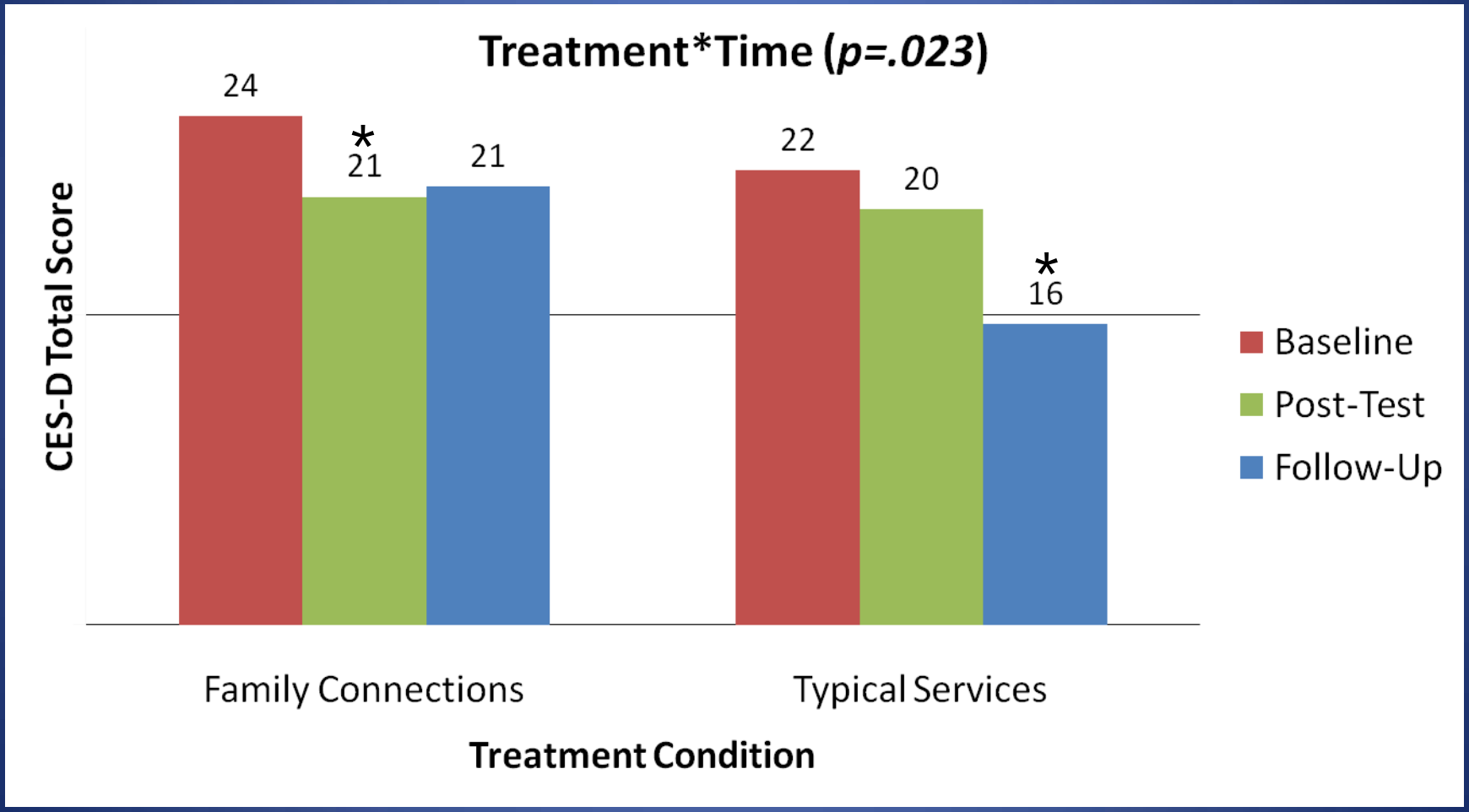
* Significant difference from preceding time point at $p < .05$

Child Behavior-Internalizing



* Significant difference from preceding time point at $p < .05$

Caregiver Depressive Symptoms



* Significant difference from preceding time point at $p < .05$

Summary: Compare *FC* families to typical services families

- *Family Connections* families showed consistent improvement in the index child's externalizing and internalizing problem behavior from baseline to post-test and follow-up. Typical services returned to baseline levels of problem behavior by the follow-up.
- The Treatment*Time interaction was more equivocal for caregiver depressive symptoms. *FC* showed earlier improvement than typical services families, but the scores remained in the clinical range at follow-up.

DID ASSIGNED SERVICE DURATION OF *FAMILY CONNECTIONS* MATTER IN TERMS OF OUTCOMES?

Assigned Dose Model

n=560 families

Site 8 was excluded due to severe lack of Post-Test and Follow-Up data.

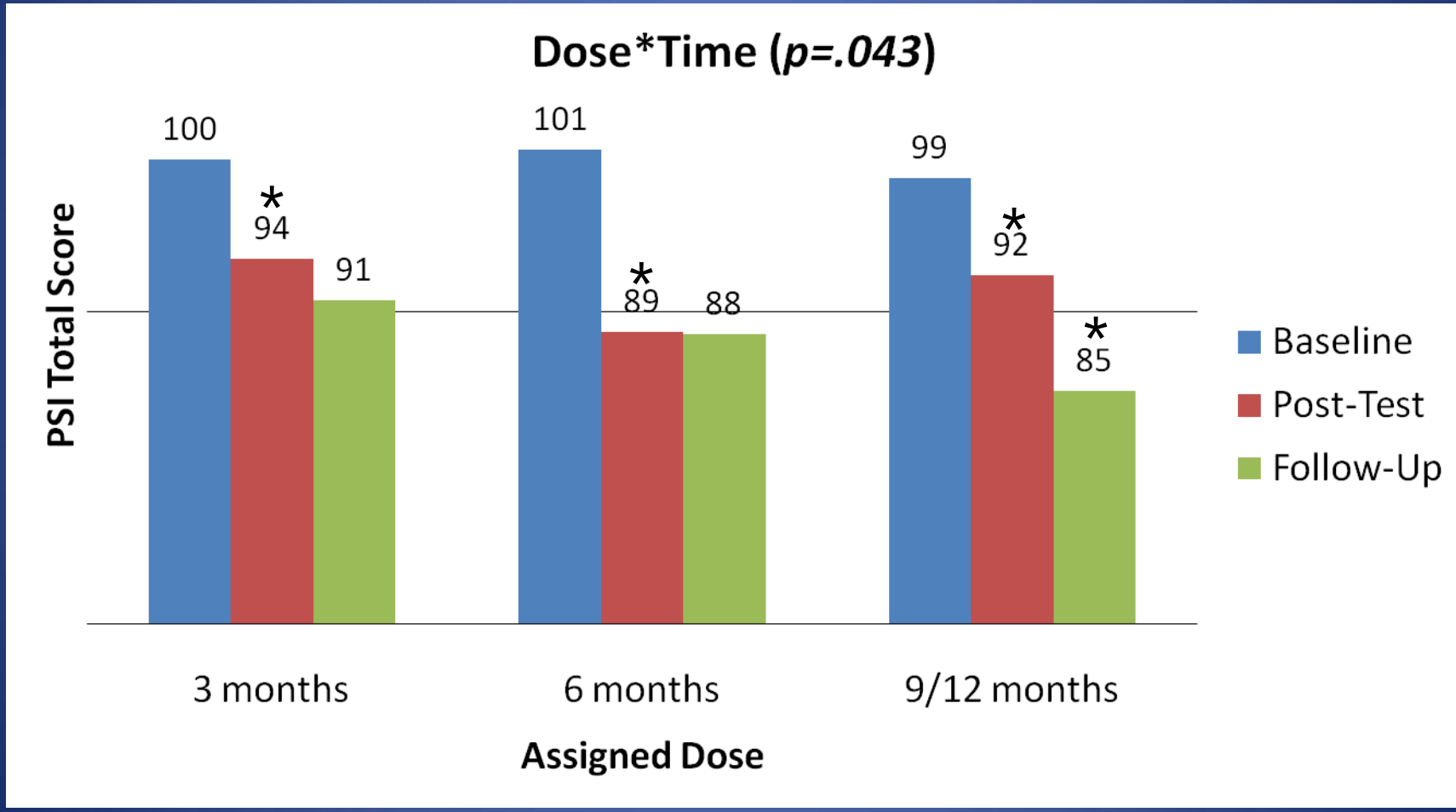
Fixed Effects

- Assigned Dose
  - 3 months (5 Sites: 1, 2, 3, 5, 7)
  - 6 months (5 Sites: 1, 2, 5, 6, 7)
  - 9 or 12 months (3 Sites: 3, 4, 6)
- Time (Baseline, Post-Test, Follow-Up)
- Significant control variables

Repeated Effects

- Time | subject=Site*FamilyID using an unstructured covariance matrix

Parental Stress



* Significant difference from preceding time point at $p < .05$

Summary: Impact of assigned service duration on outcomes

- The assigned duration of *Family Connections* service was related to improvements in parental stress over time, but not to any other outcomes.
- The Dose*Time interaction indicates that families assigned to 9 or 12 months of service showed more consistent improvement from baseline through to follow-up than either the 3 month or 6 month conditions.

DID FIDELITY TO THE *FAMILY CONNECTIONS* MODEL MODERATE IMPROVEMENTS IN OUTCOMES?

Fidelity Indicators

- Philosophical Principles
- Program Structure
- Timeliness of the Family Assessment

Fidelity Models

n=560 families

Site 8 was excluded due to severe lack of Post-Test and Follow-Up data.

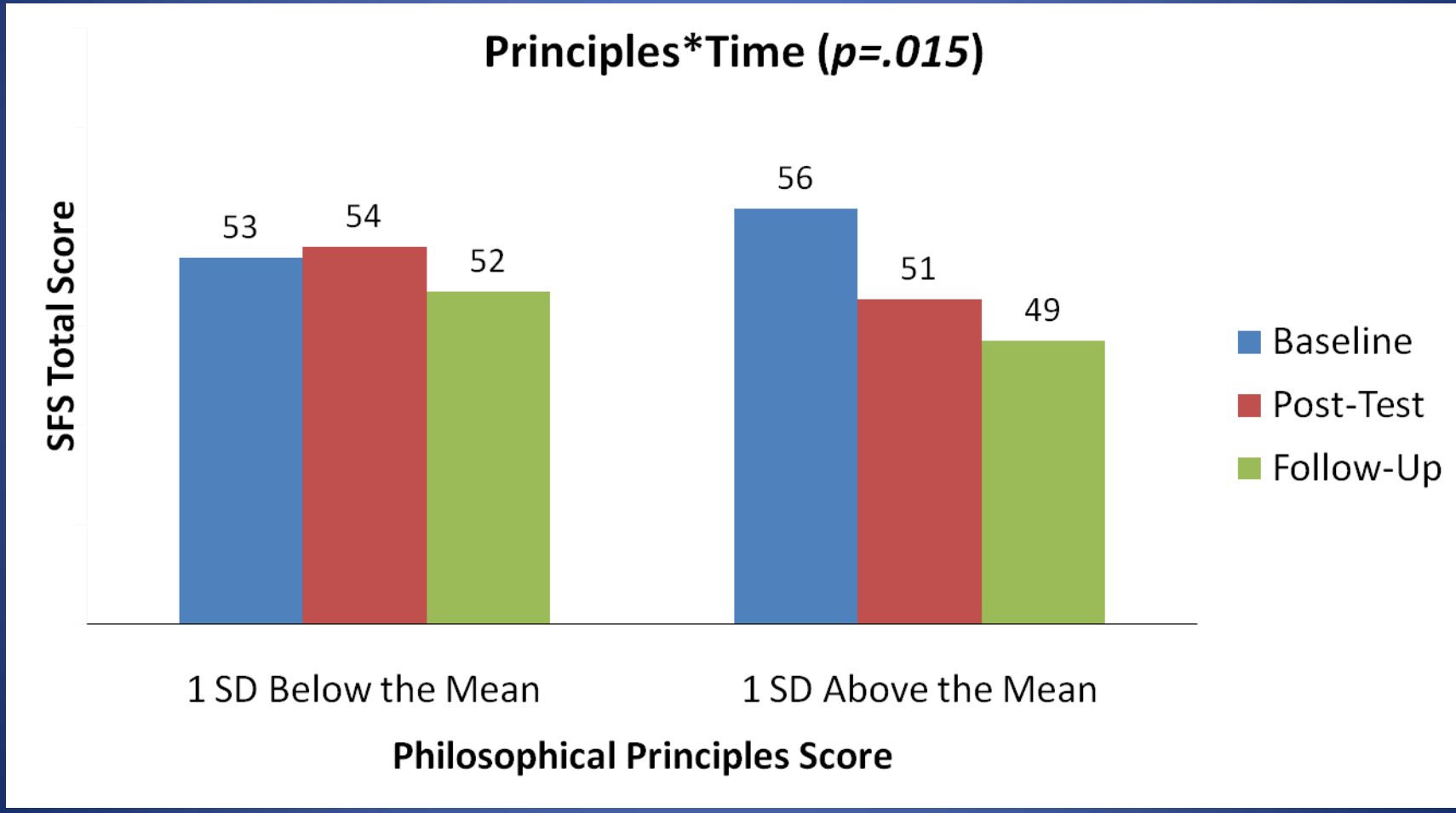
Fixed Effects

- Fidelity Indicator (as a continuous variable)
  - Philosophical Principles (mean = 21.5, min = 19.3, max = 23.1)
  - Program Structure (mean = 39.9, min = 33, max = 51)
  - Timeliness of the Family Assessment (mean = 7.9, min = 1, max = 12)
- Time (Baseline, Post-Test, Follow-Up)
- Significant control variables

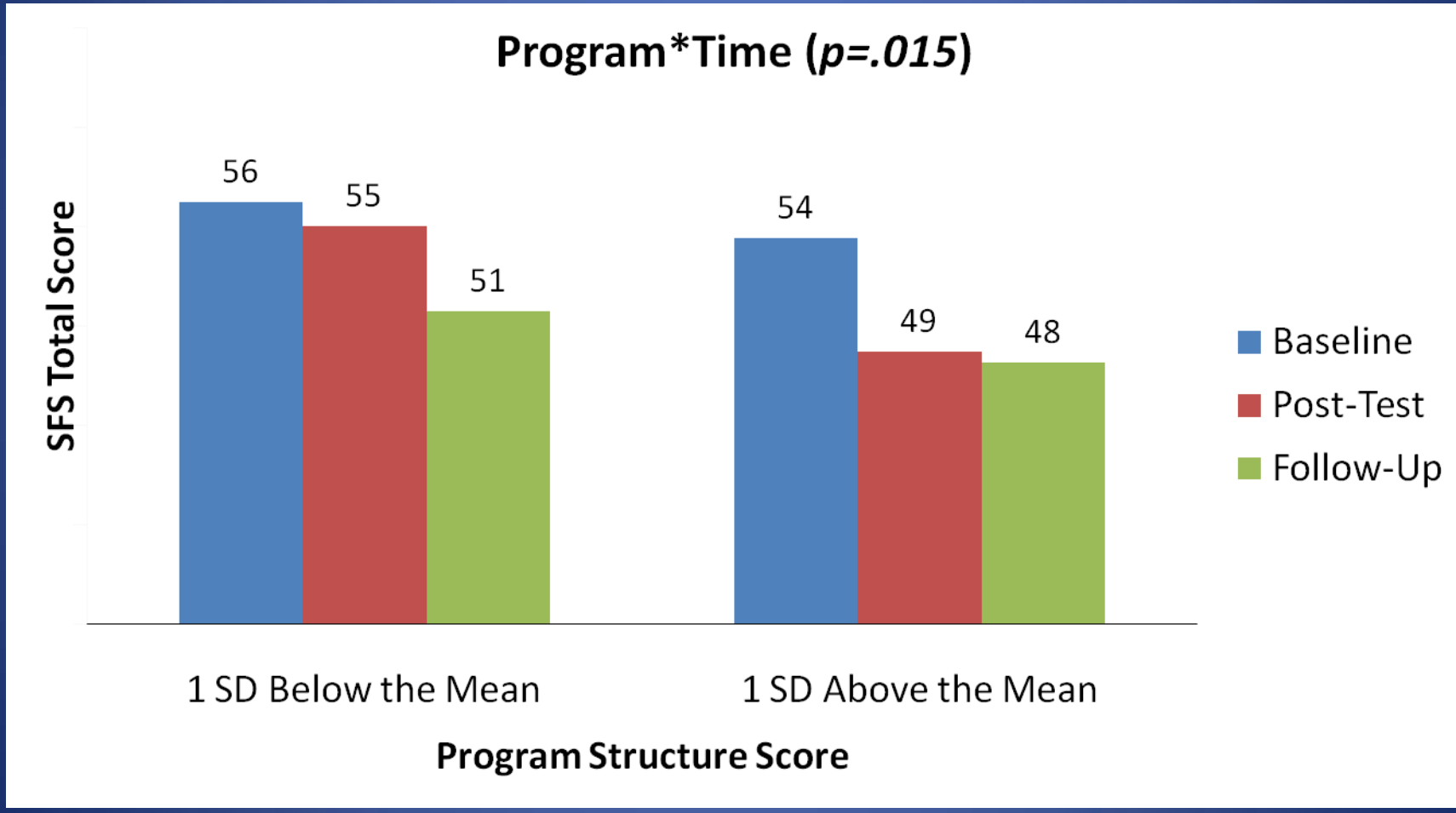
Repeated Effects

- Time | subject=Site*FamilyID using an unstructured covariance matrix

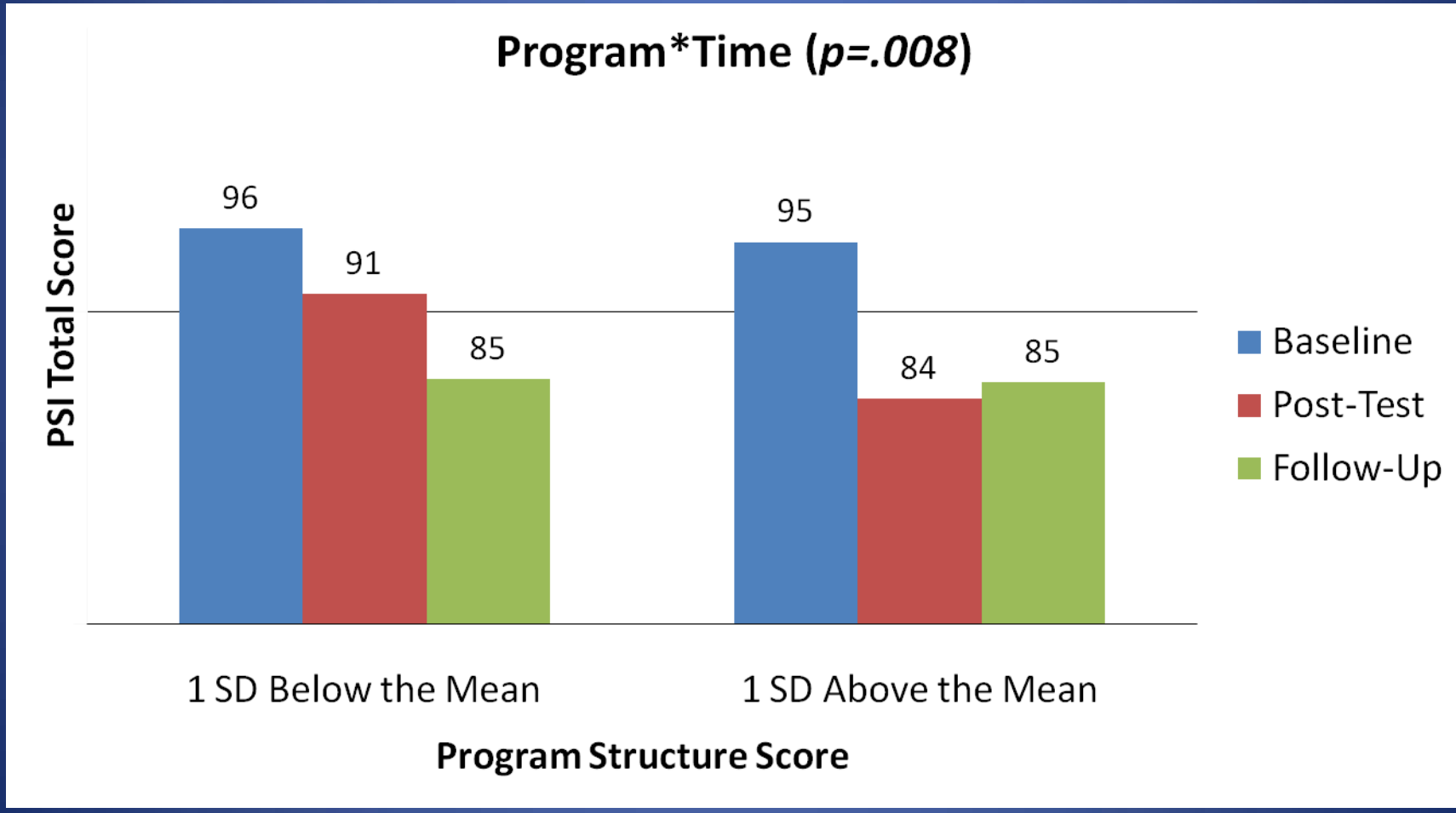
Need for Support: Principles



Need for Support: Program Structure



Parental Stress: Program Structure



Summary: Fidelity moderates improvement in outcomes

- *Family Connections* families at sites with higher scores on Philosophical Principles showed greater improvements in need for support.
- Ratings on *FC* Program Structure were associated with more rapid improvement in need for support
- Similarly, *FC* Program Structure was associated with more rapid improvement in parental stress.

Cross-Site Study Limitations

- High attrition across sites, especially at follow-up
- Not all *FC* Dose levels were assigned at every site
- The nature of typical services for non-*FC* conditions was not characterized

Discussion

- Regardless of condition, families showed significant improvement over time for all 11 outcome variables.
- *Family Connections* conditions showed differential impacts on child problem behavior, caregiver depressive symptoms, and parental stress.
- Fidelity to the *Family Connections* program model moderated outcome trajectories for need for support and for parental stress.

Clarifying Questions

Paper 3

Assessing final outcomes: Comparing differences in CPS reports by Ethnically Diverse Client Families

Diane DePanfilis & Karen Rice
University of Maryland, Baltimore

Elliott G. Smith
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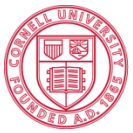
Jill H. Filene
James Bell Associates



Cornell University
College of Human Ecology

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SCHOOL OF SOCIAL WORK

Why is this important?

- The ultimate success of child maltreatment prevention programs is the actual prevention of child maltreatment

Study Question

How successful are *FC* sites in preventing child maltreatment as measured by CPS reports.

Two Samples

- 3 of 8 *FC* Replication sites submitted family-level CPS report data: 266 families
- Baltimore *FC* Program: 738 families, 2,301 children *(only a portion related to cross-site evaluation)*

Method

- Matched served families to CPS reporting data and calculated reporting rates of maltreatment prior to, during, and post intervention (family – unit of analysis)
- Cross Site
  - Predicted occurrence of post service CPS report using data from baseline measures of risk and protection
- Baltimore Site
  - Compared the time to report using survival analysis
  - Predicted the time to report using data from risk and protective factors (Cox Regression model)

Demographics Cross Site

- Caregivers (n=266)
  - 93% female
  - 41% White, 30% Asian, 18% African American
  - 27% Hispanic
  - 43% One adult in the household
  - Age range from 17 – 74, median = 36
- Families (n=266)
  - Average 3 children in the household
  - Average index child 6 years old

Demographics Baltimore Site

- Caregivers (n=738)
  - 95% female
  - 89% African American
  - 47% biological mother
  - Age range from 18 – 80, median age – 37
- Families (738)
  - Average 3 children
  - Average index child 10 years old

Predictive Variables Cross Site

- Child Behavior (CBCL) (Achenbach, 1991)
- Caregiver/Family Predictors
  - Risk Factors:
    - Parental Stress Index/SF (Abidin, 1995)
    - Depressive Symptoms (CESD) (Radloff, 1977)
    - Count of high ratings on Family Assessment Form (FAF) (Children's Bureau of Southern California, 1997)
  - Protective Factors
    - Caregivers' Empathy (AAPI) (Bavolek & Keene, 1999)
    - Support Functions Scale (SFS) (Dunst, Trivette, & Deal, 1988)
- Prior CPS Reports

Predictive Variables Baltimore

- Child Behavior (CBCL) (Achenbach, 1991)
- Caregiver/Family Predictors
  - Risk Factors:
    - Parental Stress Index/SF (Abidin, 1995)
    - Depressive Symptoms (CESD) (Radloff, 1977)
    - Stress - Every Day Stressors Index (Hall, Williams, & Greenberg, 1985)
  - Protective Factors
    - Parenting Skills (Parenting Sense of Competence) (Gibaud-Wallston & Wandersman, 2001)
    - Caregivers' Empathy (AAPI) (Bavolek & Keene, 1999)
- Prior CPS Reports

Data Analysis

- Descriptive rates of reports by group for prior, during, and post intervention
- Logistic regression analysis (Cross Site) – to predict occurrence of a CPS report within 6 months following the close of services

Data Analysis

- Event history analysis (Baltimore) – with life tables to describe the probability of a case experiencing maltreatment within 24 months of closing with Kaplan Meier method to plot the survival without a report
- Cox regression analysis (Baltimore) – to determine which risk and protective factors predict the time until report post intervention

Descriptive Results

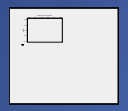
- Cross Site (n=266)
  - 14.7% of families had CPS involvement 1 year prior or during *FC*
  - 18.8% experienced at least 1 report of child abuse or neglect (1 year prior, during, or 6 months post)
  - 9.4% experienced at least 1 report of child abuse or neglect within 6 months following case closure

Descriptive Results

- Baltimore (n-753)
  - 72.5% of families had prior CPS involvement
  - 80.5% experienced at least 1 report of child abuse or neglect (prior, during, or post)
  - 19.3% experienced at least 1 report of child abuse or neglect within 24 months following case closure
  - CPS referrals peaked at 3, 14, or 20 months post case closure (Figure 1)

NOTE: data matching problems, do not cite.

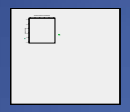
Patterns of Reports over 24 months



N = 753 Baltimore families

NOTE: data matching problems, do not cite.

Comparison of Survival Rate Prior CPS versus No Prior CPS



N = 753 Baltimore families

NOTE: data matching problems, do not cite

Regression Results – Cross Site

- Only Prior/Current CPS predicted occurrence of a post service report
  - Prior/Current CPS 12.1 times greater likelihood
- No other risk or protective factor was predictive
- Duration of *FC* intervention was not predictive

Regression Results – Baltimore

- 2 variables predicted time until recurrence
  - Prior CPS .466 times greater likelihood
  - Child behavior – for every unit change in total problem score, the time to CPS referral decreased by 5%

NOTE: data matching problems, do not cite

Limitations

- At the time of this paper, only 3 sites had submitted their CPS data
- Data matching problems with the Baltimore data, missing caregiver variables, duplicate reports may have been counted due to MIS conversion problems
- State CPS data systems at large may have serious validity problems at the case level

Implications/Discussion

- Programs may have prevented future maltreatment however research designs make comparisons difficult to compare.
- High-risk families are subject to high levels of surveillance
- Child maltreatment reports (as identified in state CPS data systems) are imperfect measures of prevention

Clarifying Questions

Questions & Discussion

Questions later:

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