

Secondary Data Analysis From the National Survey on Child and Adolescent Well-Being

Prevention Webinar Presented by the
Federal Interagency Work Group on Child Abuse and Neglect

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Presenters: Barbara J. Burns, Ph.D., Duke University School of Medicine; Sandra Jee, Ph.D., University of Rochester Medical Center; and Dana Schultz, Ph.D., Rand Corporation

Melissa Brodowski: [00:00] I'm with the Office on Child Abuse and Neglect at the Children's Bureau, and I am so pleased to invite everyone to this informational conference call that we've set up, hosted by the Prevention Subcommittee of the Federal Interagency Work Group on Child Abuse and Neglect. Some of you may know, but the Office on Child Abuse and Neglect actually has the lead in Federal interagency collaborative efforts related to child abuse and neglect. Catherine Nolan is our director, and she chairs this Federal Interagency Work Group. And last year we started a Prevention Subcommittee of the workgroup as a way to bring together Federal staff from different agencies who share a common interest in child maltreatment prevention. So we have staff who join us from the CDC, Maternal and Child Health, NIH, the Department of Defense, Department of Agriculture, Child Care, Office of Special Ed., ACF. And the Office of Planning, Research, and Evaluation has also been a very active member.

So we are very excited that they have agreed to host one of these calls to share some of the exciting work that is happening with some of the research grants that they have funded. I know we have a broad group of people who have registered for this webinar. We actually sent the application pretty far and wide to our grantees, as well as Federal agency partners and really encouraged them to share it with other people, so I'm sure there is really a whole host of folks involved in this call. We really did want this to be a nice opportunity to share research information but really get into some practice discussions as well and implications. Hopefully, we'll have a nice, lively discussion. The one thing to note—I think Jean was mentioning it—is please put your phones on mute unless you have a question....

[instructions to callers]

So I think we were going to go through a presentation at a time and then open it up to some questions immediately after those presentations, and hopefully we can keep track of time and make sure that everyone gets a chance to share their information. I also want to acknowledge all the work that Jean Nussbaum with the Office on Child Abuse and Neglect has done to really prepare and organize this webinar. That's why we're here. So now I want to hand it over to Lauren Supplee, who is the project manager for these grants.

Lauren Supplee: [02:56] Thank you Melissa. I, too, am happy this is happening. There was a lot of work and preparation. Thank you, Jean.

I just wanted to briefly talk about what is OPRE or the Office of Planning, Research, and Evaluation and about the data set that the three presentations today are going to be based upon using secondary data analysis. OPRE is the primary research wing of the Administration for Children and Families, and we are responsible for conducting research on the effectiveness and efficiency of ACF programs. Our office does research on wide-ranging topics from abuse and neglect, child care, Head Start and early Head Start, runaway youth, strengthening families, healthy marriage, welfare, and employment research.

Two of the projects—this is sort of a joint effort where two projects are overlapping our office. One is the primary project, which is the National Study of Child and Adolescent Well-Being, which is NSCAW. Then we also put out secondary analysis grants to encourage people to use the data sets after we've collected them. All of the presentations today are going to be talking about what we call NSCAW 1. There is currently in the field an NSCAW 2, which will be collecting a whole new sample of data. I just wanted to make that clear. NSCAW 1 was the first nationally recognized representative, longitudinal study of children who came in contact with the child welfare system, and it was really important because it included, for the first time, firsthand reports of children, parents, caregivers, as well as caseworkers, teachers, administrative records. And it allowed us to examine both child and family well-being outcomes, but also to relate those characteristics to the family, the community, and the child welfare system.

The sample includes more than 5,501 children that were from ages 2 to 14, and they came from 97 child welfare agencies nationwide. The samples are drawn from the cases that were either investigated or assessed. So they just had to have contact with the child protective service agency. So it includes both open and unopened cases, substantiated and unsubstantiated cases. It includes children both being served in their homes and out-of-home care. They were recruited between October 1999 and December 2000, and we have then followed them for 5 years so we have five waves of data on the children. Then we had a subsample of children, of 727 children, who we termed long-term foster care, so that would allow additional analyses on those particular children and their outcomes.

So I'm very happy to now turn it over to our first presenter, Dr. Barbara Burns, who is going to be talking about some of the results of this data set.

]Barbara Burns: [06:17] Let me start by talking a little bit about why we were concerned about caregiver depression in the national study. As you know, depression occurs at very high rates in the general population: 17 percent for women lifetime and 7 percent on an annual basis. Women who are on welfare, the rate is 25 percent, and we also know that children of depressed parents are much more likely to have mental health problems. A recent Canadian study of depressed mothers and children showed that the impact on girls over boys was greater and more long-term than boys. What we do know, on the positive side, is that depression is treatable. However, in the general population about 70 percent of depressed woman go for treatment; 30 percent do not access services. You'll see some comparisons as I get into the data.

There is some evidence from several studies that when depressed mothers are treated that, in fact, their children get better. To a great extent, what we're facing with this population of

caregivers is that many of them are children of depressed parents; they're also children who were experiencing high rates of abuse in their youth and thus, probably developed limited parenting skills. Depression also affects the ability to bond with children. The further impact of the kids' behavioral problems on the parents may, in fact, increase their depression as well. So, clearly, depression is a big issue for child welfare.

The study aims are clearly there, and I'll try not to read most of what's on the screen for you. But what's associated with major depression in these caregivers in contact with child welfare for investigative maltreatment cases is to look at the long-term outcomes of these caregivers with depression. To what extent they get services? And then to look at the impact on children, primarily their placement and subsequent maltreatment. Methods for the study were just described. This sample is a little different in that we did not look at families with children under 2 because we don't have mental health measures on those children. They don't go down that low. We just looked at the caregivers whose children were at home at baseline. We looked at baseline, 18 and 36 month follow-ups. We didn't have the other two that were mentioned earlier. You'll see a list of measures. There are many more, but these are the ones that were used in this particular study. And what I want to emphasize is that it's a measure of depression and substance abuse; it was a standardized measure.

So, first of all, how do depressed caregivers differ from nondepressed caregivers? More in poverty, the substance dependence rate is three times that in the nondepressed caregivers. So that's another risk factor. We used the child behavior checklist clinical range scores as an indicator of need for treatment. For internalizing disorders, which we think of as anxiety, depression, trauma [inaudible], the rate of internalizing disorders in these kids versus 25, the rate of externalizing is much higher, around 58 percent, so a much greater clinical need than for nondepressed caregivers. We see also, on the positive side, that there is a good chance of getting into mental health care, over half of them.

The placement finding is interesting in that the placement rate is a little higher, 16 percent versus 15 percent for nondepressed caregivers. Any further maltreatment report by 36 months is much higher than for the nondepressed caregivers.

I'm not talking about the fathers. There were very few male caregivers in the study, so it's not surprising that depressed caregivers are largely female. They either have less than a high school education or, interestingly, a college degree. They have female children and children with a history of sexual abuse. These are associated with depressed caregivers.

So what happens to the depressed caregivers in terms of services received? So, comparing depressed to nondepressed--recall that the nondepressed group also will have in it caregivers with other mental health conditions. So we started at baseline. We had 25 percent of them getting some care. By 36 months out, it goes up to 35 percent. So that contrasts with the 70 percent that I was telling you about earlier with depressed women getting help, and that's actually for a year.

To what extent do caregivers recover from the depression, and what's the relationship between that and receiving some mental health services? You'll see that the full recovery group, 44

percent, actually had the lowest rate of mental health services use. The highest rates were the no recovery group, and many of them got recognized later.

The picture here overall is that if you add full recovery to delayed recovery, between 18 and 36 months, that over 3 years 60 percent actually were recovered from depression. Not a very positive rate for that time period. We did a fancy analysis, which you'll see soon, and have laid out here for you the caregiver variables and the child variables that we've used. And I've already described those a little bit.

So, the first question: What's the relationship between caregivers getting mental health service and the child being in the clinical range needing treatment?

And the answer is this is a positive relationship, but it's not a very strong one. OR means odds ratio, which means a little better than one... likelihood of getting care if they're in this clinical range.

So what's the relationship between caregiver depression and child clinical status?

The answer here is a very strong relationship. Odds of nearly three. What if the caregiver gets mental health services? The odds go down to below two, so there is a positive effect of mental health service use on child clinical need.

How about the impact on placement?

Lots of worry about stigma issues, worry about revealing depression.

[background noise]

Various factors, as we know affect placement. What you see on the top part of this table is an older caregiver, more risk factors. Understandable, this population has many risk factors from poverty to family violence.

What if mental health services are provided to the caregiver?

It is not the caregiver depression predicting child placement, it's the high risk factors and a subsequent report of maltreatment. Now remember that the nondepressed caregivers had a slightly higher rate of placement than the depressed caregivers. [laughter]

What's the impact of caregiver depression on a report of subsequent maltreatment?

We threw in all these variables, and you'll see many significant predictors of subsequent maltreatment. These are familiar to you from your experience in the field and from the literature. If you look at the second model, the fact of caregiver mental health service provision actually reduces the likelihood of subsequent maltreatment.

So just moving quickly for two other presenters coming... A brief summary: Caregiver depression is prevalent. Remember that 40 percent rate in contrast to a population rate of 7 percent among women? Youth are very likely to need clinical treatment, and our recovery rate over such a long time is low. Mental health service use for caregivers is low. Why are we not getting more of these caregivers into treatment? Only a third of them. Clearly, some of them didn't need it because they recovered on their own, but this doesn't change much over time. I've talked about the relationship between the clinical needs of the youth and the caregiver's depression and mental health service use, that placement is predicted by factors other than caregiver depression or caregiver service use should not make service use be perceived as a barrier. The fact of a new report of child maltreatment associated with service use could be a worry for the caregiver but certainly is a reassuring finding for the child welfare system.

So what are the implications? Clearly a need to screen for depression in caregivers and probably substance dependence and use as well and the need to screen for clinical need among children. And this suggests screening for both. A current initiative supported by the Casey Foundation is in the process of trying to develop some screening guidelines as well as others.

There is some prior research that treating parents will benefit children; we haven't found that yet here, but we know little about the quality of the mental health care that was provided for the parents as well as for the youth. That the children were more likely to receive mental health services is encouraging while the low rate for caregivers is discouraging. There are probably any number of factors related to that, such as access to the adult mental health system for the caregivers, the fact that the adult caregivers are not necessarily going to be eligible for Medicaid, that many of these parents and caregivers have had negative services--negative experiences with these systems. And I think what's really needed is the provision of care for both caregiver and child in the same setting and preferably from the same provider. I did find, in the literature, one intervention called Cognitive Behavioral Family Interaction Therapy in which the clinician worked with the mother/caregiver in the home, treated her depression with cognitive behavioral therapy, and administered parent management training to help her address the child's behavioral problems.

Thank you.

Ms. Brodowski: [20:12] Great. Thanks Barbara. I just wanted to see if anyone has any questions that they wanted to raise right now, right after this presentation.

Audience Member 1: [20:21] On the first slide, did you look at the whole age span of kids?

Dr. Burns: [20:30] No, age 2 up to 14 at that time.

Audience Member 1: [20:33] Did you see if there are any age differences as far as whether the child that was referred was school-aged or adolescent? I'm just curious about this interaction you see between the child clinical level and seeking mental health care?

Dr. Burns: [20:50] I can't answer that right at the moment. This is coming from a very lengthy and detailed chapter that's been prepared for a book about NSCAW. If you email me, I can see what I can do for you on that.

[Audience member requested the name of the journal where the research on Cognitive Behavioral Family Interaction Therapy was printed:

Behavior Therapy, Volume 31, Issue 1, Winter 2000, Pages 89-112

Matthew R. Sanders and Margaret McFarland]

Sandra Jee: [22:36] This is Sandy Jee from the University of Rochester. Were you able to look at differences by placement type in terms of the rates of depression because I'm wondering if when they assess the kids... I think the caregiver are the ones who are present at that time, which would be maybe 8 to 12 months after the original CPS report. And I'm wondering if some of the kids were with their original biological families, which I think many of them were... Were you seeing high rates of depression in foster parents or in kinship caregivers? I'm just wondering about the length of time that the kids were exposed to a suboptimal mental health environment. Is it lifelong exposure to a depressed caregiver or could it have been somebody who was a foster parent who just also happened to be depressed and started taking care of the kid the week before?

Dr. Burns: [23:46] I don't think I can answer a lot of those questions. Let me say that these were children who were at home at baseline so they were their natural caregivers, and foster caregivers were not assessed for depression. So over that 36-month period, 15 to 16 percent of them were placed out of home. What was interesting to me is that the rate for placement of kids with depressed caregivers was a little lower (15 percent) than nondepressed caregivers (16 percent).

[audience exchange]

Shannon Brown: [26:00] This is Shannon Brown from the CDC. I wondered if there was any way to control for...to think through the potential of reporting bias of the depressed moms on the CBCL? We know that from past literature that depressed mothers often rate their children as having more internalizing and externalizing problems. So it's sort of a struggle to think of that as a differentiating factor from the mothers who aren't depressed because of the reporting bias that could be there.

Dr. Burns: [26:29] That's possible that it's slightly elevated, but I don't know of any way to control for it

Audience Member 2: [26:42] There's probably a lot of co-occurrence between depression and domestic violence. I was wondering, have you done any analysis of whether or not these women are getting domestic violence services, and if this mental health treatment is necessarily the appropriate treatment for cases where there is a co-occurrence of domestic violence and mental health?

Dr. Burns: [27:14] We know there are pretty high rates of domestic violence. I have not myself looked at services for domestic violence, but I believe that's another future opportunity.

Audience Member 3: [27:35] The difference in placement rates of 15 percent and 16 percent between kids of depressed and nondepressed caregivers, is that significant?

Dr. Burns: [27:45] Actually it is, but I don't know that it's meaningful.

Audience Member 4: [27:52] We have completed the analysis of maternal depression [in mothers] of children that are less than 5 years old, and we submitted a manuscript to the juvenile child abuse and neglect...There is going to be a briefing on the NSCAW website about maternal depression among mothers of young children. One of the main predictors was intimate partner violence and also health problems among the mothers. We still are waiting for some team to look at the impact on young children's outcomes and now that the wave 5 is available we think that definitely some people can look at that.

Dr. Burns: [28:48] Thank you for answering two other questions. Glad you were there.

Audience Member 5: I have a question about the earlier point on the percentage of women who were depressed that had a history of sexual abuse as children. Do you know if, when they received treatment, if they also received trauma treatment?

[exchange clarifying the question]

Dr. Burns: [29:36] We don't have any idea. They're asked, are you getting mental health service for emotional, behavioral problems?

Ms. Brodowski: [29:54] Anybody else before we go on? A lot of great questions.

[background exchanges/technical details on next presentation]

Sandra H. Jee: [31:15] Thank you for listening in. This is Sandy Jee from the University of Rochester. Just so you know about me, this is my first presenting webinar so I hope it goes OK from a technical standpoint. I am a primary care pediatrician and a professor of pediatrics here at University of Rochester, and my area of research inquiry is in foster care and also in the intersection between mental health and primary care. My clinical work in seeing patients involves taking care of children who are in foster care and also in the general pediatrics clinic in our university clinic here. In Rochester, New York, we have a specialized clinic that focuses on caring for children in foster care, and we provide primary care to all children who are in family-based foster care. So a lot of questions that we were trying to address and that we're thinking about are things that we see day-to-day in our clinical work.

So I wanted to talk about three studies using NSCAW. The first two have been presented at the Pediatric Academics Societies' annual meeting and focus on mental health issues for children who are in foster care and kinship care. The third study is on resilience for maltreated children. I'll just give you a brief overview of these studies and then conclude with some implications for practice and policy.

So our first study is a study that was presented by Dr. Szilagyi who's one of my colleagues and mentors here. As many of you who are practitioners maybe know— especially those who work in health care and social services fields—there are national guidelines that are in place for mental health assessments for children who are in foster care. The American Academy of Pediatrics (the AAP), and the American Academy of Child and Adolescent Psychiatry, and the Child Welfare League of America all recommend that children who are placed in foster care have a mental health evaluation by a trained mental health professional as part of their comprehensive health assessment.

So what we wanted to do in this first study was to assess nationally, using the NSCAW, among young children who were in foster or kinship care two things: We wanted to know about the prevalence of prior trauma in the form of maltreatment, domestic violence—I think someone in the group was interested in DV— and caregiver impairment. Because we felt that these were really important and have long-term effects on their mental health outcomes. And secondly, we wanted to look at the association between having prior trauma and subsequent outpatient specialty mental health utilization. This was to find if services were received from a mental health clinician or community mental health center or day treatment program or a therapeutic nursery. We felt that this study was an important starting point to lay the groundwork for resilience because we wanted to increase awareness in the pediatric medical literature about traumatic experiences that children in this group [inaudible].

This was a cross-sectional analysis. What we did with wave 1 was look at the casework respondent data, and we looked at what caseworkers were reporting for children who were age 3 to 10 years when they were placed in foster or in kinship care. Because of time limitations, we're just showing some of our key findings, but I wanted to talk about the maltreatment in particular. So 69 percent of children in this sample were maltreated prior to placement in foster or kinship care. So it makes sense that something bad happens and they're maltreated, but this was to find if having experienced physical abuse, sexual, emotional abuse, neglect, or other—and the major item in the other category was abandonment... So they had experienced high levels of trauma prior to placement. Twenty-three percent had been exposed to domestic violence, and 88 percent had a significantly impaired caregiver. So Barbara was talking about depression, and this includes mental health problems and adult serious mental illness, cognitive impairment, active alcohol abuse or drug abuse, and significantly poor parenting skills. So very high rates. And this is just really astounding to us. I told you I see these kids on a day-to-day basis for their medical issues, but you think of the implications of this type of trauma and stress for the child and their long-term outcomes, it's just really astounding.

We tried to look at what kind of health care do kids who have been exposed to these high levels of maltreatment, domestic violence, and caregiver impairment get? Well, I think the story is that the glass is partially full but not totally full. And what I mean by that is when we look at outpatient specialty mental health service use, within the 12 months after the initial child protective services report, overall, almost 37 percent of children were receiving services or about one-third. So when you break it down by placement type for foster and kinship, more children in foster care, or 52 percent, were getting some kind of outpatient specialty mental health services, but only 28 percent of children in kinship care were accessing services. This was a statistically significant difference.

When you think about it, a child being placed in foster care would have had what I would consider varying levels of surveillance or supervision people—looking out for them or their needs, so it makes sense that they would be accessing service but certainly not everybody was getting services as we might have hoped or expected. And here we see the results for the 69 percent of children who experienced maltreatment and the percent of children with outpatient specialty mental health utilization is shown by the primary type of maltreatment they experienced. You can see this in the aqua bar. So certainly there's spots of overlap between these and among these categories, and these were just by the primary type of maltreatment. And you can see that on the left hand side there is certainly a trend towards higher rates of access for services for children who have been physically and sexually abused. Because of the small sample sizes in all these groups they were not statistically significant differences, but the trend was certainly there.

So, the conclusion from this study was that there are high levels of maltreatment in the population, 69 percent of children in kinship and foster care had experienced maltreatment, as has been shown in prior work by our colleagues in similar samples using this data set. Only about one-third had any outpatient specialty mental health service use, despite recommendations by national organizations. So you think of that disparity between what kids have experienced and what they're really getting. There is a huge gap there. So what does this really mean for all of us who are on the frontlines trying to figure it out when we see these kids day-to-day? What to do for them? I think there are certainly hurdles we must leap, and we must be mindful of the complex trauma that many of these kids and youth have experienced.

Secondly, I wanted to talk a little bit about posttraumatic stress, going back to our roadmap here. We've talked about traumatic experiences for children, and I want to talk about what happens to adolescents over time. This is the paper that we presented also at the Pediatric Academic Societies. Really, my interest in adolescence...I have a particular interest in adolescents because I see them, and I think they need a lot of help. But a recent Casey report—I think somebody here is from Casey—had estimated that nearly a quarter of youth aging out of foster care have posttraumatic stress disorder. And I think this is a problem that I see clinically. Kids, adolescents, that I see come in with internalizing symptoms, headaches, and stomach aches, and we do the medical work up and there often, I really think, there is a mind-added connection there. And this Casey study made us think about how we can look at posttraumatic stress in the national survey of child and adolescent well-being. And what we wanted to do was to look at the prevalence of posttraumatic stress symptoms among youth who are in foster care early in adolescence and to see how posttraumatic stress persists over time also in relation to services that they receive. So we looked longitudinally at children or teens at wave 1 and 18 months later at wave 3. Posttraumatic stress was defined as having a borderline clinical significance score using a previously validated trauma symptom checklist for children.

Here again is just some of the data. It is pretty interesting. So out of the 5,501 children in this sample; 1,351 [inaudible] in the age group that we were looking at. And you can see there are the breakdowns by placement type. So it gets pretty small because you can see about 12 percent were in foster care, 10 percent in kinship care, and then the majority stayed with their birth families. But what was really interesting was that the prevalence of posttraumatic stress for the overall sample was 9 percent at the first time point and 7 percent at the second time point, and

the trauma symptoms checklist scores were actually in the average range. And when we looked at differences by placement type, originally in wave 1 we saw higher rates in foster care, which we would've expected just thinking about the trauma of being removed and placed in a different family. We did not find significant differences, at least statistically, in the scores by placement type.

When we looked at the mental health service use over time, we found that about (you can see in the top line) about 32 percent of our overall group were getting some kind of mental health services over time. And as we saw in our other study, kids who are in foster care were getting more services, 57 percent, more than in kinship care—a little bit more than in the birth family—and this was statistically significant at some differences. But the rates of posttraumatic stress, while they were higher than we would've liked at all, they were not as high as we would've predicated based on the Casey report of nearly a quarter of young adults with rates of posttraumatic stress that were nearly double that of war veterans. So I'm not sure exactly what to make of this. I'm not sure if we will need to follow kids over time or try to figure out what is happening for kids who remain in the system, but at least we were not seeing overwhelmingly high rates of posttraumatic stress at this time.

So conclusions from this study: It was that the prevalence of posttraumatic stress was a little bit lower than we expected during early adolescence, than we would've anticipated by reports of young adults who are aging out of care. But it may be that the youth who were aging out of the system may have more posttraumatic stress than adolescents who have different types of placement histories. And when we looked at receiving services, it did seem that those who had received services, especially those who are in foster care who were receiving services, seem to have a positive impact on posttraumatic stress over time. So I think that was probably a positive message. But what to make of this? Well, we started out by saying that the children that we see are experiencing high rates of maltreatment and then we looked at what was happening to teens over time, and it looks like some teens are getting mental health services and are helped by this, but there is still a ways to go.

So we want to try to figure out what are we hoping for for these kids. And really what we're hoping is that we see more resilience, and I think Dr. Schultz is also talking about resilience too. I won't go too much into the background, but just to remind us that resilience is really a positive adaptation despite having experienced really terrible [inaudible] that would normally lead to maladjustment. So it makes sense to expect that children who experience numerous adverse life experiences are likely to have some sort of result in synergistic negative impact on their well-being. But—this is supposed to be a river, it's kind of blurry—but it's supposed to be dynamic. Resilience is not a static concept; it's changing over time and that's what, I think, makes it challenging to measure.

Various things go into resilience. Child factors include temperament, IQ, what we call the internal locus of control, and self-esteem, and these are perhaps less mutable but important factors to consider. Then there are the family factors that we have to consider. Having a nurturing family member—as Dr. Burns said, a caregiver who is not depressed—competent older siblings in the home, nurturing extended kin, having appropriate rules and expectations, and appropriate parental monitoring behavior. So these are all things that impact our resilience. So

what we wanted to do was to use a previously defined framework for resilience that was developed by Dante Cicchetti and our colleagues at the Mt. Hope Family Center here, and this has broken resilience down into the seven domains, as you see here on the left. And we tried to use the NSCAW measures on the right to measure different concepts of resilience and make a summative score to use over time.

So, we usually include growth curves to model trajectories over time—I know this is a little bit confusing—but what I basically want to show is that we’re looking at three different time points to see what’s happening to children at these different points looking at the data. And here, when you look at resiliency over time, this is just combining everything. You can see that initially it starts out very low and then there is an initial [inaudible] resilience score and then it seems to dissipate a little bit over time. And I think what we may be seeing here is sort of a supervision effect. So you see a big jump right [inaudible] as people are involved in putting services in place, and at least in wave 4, it comes up as our third data collection point, but you know, years out we may see this [inaudible] starts and ends up better than where it started.

When we looked at this by child race or ethnicity, I think the interesting thing to take away from this point when we look at overall resilience for these groups is, if you can see the Hispanic or the Latino group that’s in tan, it’s right behind the green, that is the only group that continues to go up and show increased resilience. We’re not sure exactly why that is. If it may be community level factors or other supports that may be causing that. But you can see certainly for the Black/non-Hispanic and the White/non-Hispanic, the resiliency scores they go up initially—again, as I said, probably as a supervision effect—and then they tend to go down but they’re still very, very low and not where we would really hope somebody who is resilient is. Then when we looked by placement—as I said I worked foster care and I was really interested to see what we see in foster care—I think the most interesting thing about this is that you can see the children who are in the group homes, and they are in tan here, they start out with very low resilience scores and they actually drop initially and then they tend to go up. Whereas all the other groups—again, you see an initial surge and then go down—actually kinship care probably because they’re still with kin, they tend to go up.

So I think our conclusion from this study is that resiliency is challenged because it’s a hard concept to measure, and there are many things that go into it. And we can make a resiliency composite score, and it shows us that children sort of decrease in their resilience functioning over time, but they initially showed an increase. Only Hispanic or Latino youths were able to maintain resilience over time. So we wanted to end with implications for practice and policy. I think that we really need to think why children who are experiencing maltreatment are not receiving outpatient specialty mental health services? And this goes back to our first point that, why are the majority of children who are maltreated not receiving outpatient specialty mental health services? You know, is that an effect of not accessing services, is that an effect of a shortage of mental health providers? I’m not sure. Secondly, we need longitudinal studies to really understand posttraumatic stress. You know, how prevalent it is and really what ends up happening in early and late adolescence. And how we can use services to improve their long-term outcomes. And, lastly, we need additional resources for all of these children, especially those who are older in our system.

Here's a picture of a little kid that I see in my clinic who used to be in foster care and now I see him in my regular clinic, who's been adopted by this family. We just want to keep healthy children in families in mind. Thanks.

Ms. Brodowski: [50:40] Great, thanks Sandy. I especially love the picture.

So we definitely want to open it up. I know there was a lot of information, you know the three studies and all, so if people have questions please go ahead and unmute your lines.

Audience Member 6: [51:00] Hi, I have a question. Which measure of trauma treatment did you use? What I mean, is by substantiation status and if you applied the weight it's only about one-third of that sample are maltreated.

Dr. Jee: [51:12] Are you referring to our first study?

Audience Member 6: [51:18] Study A

Dr. Jee: [51:20] Ok, can you repeat your question again?

:Audience Member 6: [51:25] Which measure of trauma treatment did you use? Because when I use substantiation status and the weight, it's only about one-third, not 69 percent.

Dr. Jee: [51:36] I'm sorry, I don't know the answer to that question, but I believe it was from the caregiver report of maltreatment and trauma exposure. So I will have to go back to that and see.

Audience Member 7: [52:00] Hi, can I ask you a question?

Dr. Jee: [52:01] Sure.

Audience Member 7: [52:03] Actually, I think it's more like a comment. When looking at the differences between the kids in foster care and the kids who are in kinship and with their birth families and the discrepancy in their receipt of the mental health services... I also think that it is important to think about the cultural attitudes that have to go along with wanting to either be supportive of mental health services and just...I think it has a lot to do with different cultures' views on getting help. Even the word mental health can cause a lot of mixed emotions in people. So I think that could also have some kind of... or make some sort of difference in between the two populations.

Dr. Jee: [52:47] Right, I think that is an excellent point. Are you a mental health provider? Or you just happen to know?

Audience Member 7: [52:54] Well, I have a psychological and biological background. I think you can just see that a lot with the people when you look across different races and ethnicities and even religious standpoints, when it comes to accepting either that you need help or going to actually get the help.

Dr. Jee: [53:13] Right, I think that is an excellent point. And also thinking about the differences between foster and kinship care because I think there's also this idea in kinship care that, if it is a relative that they're close to, they may feel that they don't really need the help or it's almost that there's some stigma attached to that versus in foster care there's often so much supervision and caseworkers and people involved who are telling you to go to this appointment and that. It becomes more of a mandate to go to services or get an evaluation than in kinship care. Depending on what State you live in—in some States kinship care falls under foster care and in some States kinship care is very separate—there may not be that mandate of somebody needing to get an appointment. Also that cultural acceptance... I agree completely that even talking about mental health can be very tricky... Sometimes, as a pediatrician, I'll phrase it more as behavioral problems or stress because if you can relate it to something that the parent wants to fix in their everyday environment then they may be more available to getting help than somebody telling them to get an appointment where they already have 10 appointments that week. That's a good point.

Ms. Brodowski: [54:41] Any other questions?

Gail Ritchie: [54:42] This is Gail Ritchie from SAMHSA. Thank you very much for your presentation. I have a question, but a brief comment. I want to thank you for reminding us again that resilience is a process, it's a positive adaptation and not a child trait, which so many people I think mistakenly.

Dr. Jee: [55:01] Right.

Ms. Ritchie: [55:02] Here's my question. We are concerned about the gap in mental health services for those that are transferring from the child mental health system to the adult mental health system. And it sounds like you've given us another facet of the problem to look at, which is that folks that are in foster care may not have gotten the treatment even they needed, and so we've got to help them think about that and be alert that they may have a posttraumatic stress disorder as they leave the child system and move into the adult system.

Dr. Jee: [55:36] Right, certainly. It sounds completely right. I think about posttraumatic stress a lot with teenagers, really more with teenage girls because they are the ones who come in for help. I think that the teenage boys are probably suffering, but they're less willing to get help. Then their problems are manifest more as conduct disorders or externalizing problems. Sometimes it's getting the recognition for the teen that they would benefit from getting services, and also, even once they get hooked up with a therapist sometimes as they age out of care then they lose that coverage. Oftentimes there aren't enough providers to keep that service going, and so I often see that as teens are ending their time in foster care then the therapist may say, OK now we need to end care or try to figure out how to transition.

It is very challenging, and I think long term this will be more of a systemic problem, and primary care providers will really need to be shifting their focus more to managing these within their own offices instead of trying to refer everything out. We have this concept in our clinic and in many pediatric clinics, they call it the pediatric medical home where really we try to take a more

comprehensive look at the child. So we really do not see it as, refer to mental health if we really don't want to know anything about it. But we are trying to even bring in mental health providers, developmental providers into our office site so that we can unify the services for the child. And I think the more that we sort of shift the focus to enabling providers and also the children and their families themselves to get the help for themselves, I think will help improve their long...

Ms. Ritchie: [57:45] I think that sounds like a village within...to do right by the child. I couldn't agree more, thanks so much.

Nancy Seibel: [57:51] Hi. This is Nancy Seibel. Dr. Jee, I had a question about...it looks like accessing mental health services was higher among children in foster care who had been physically or sexually abused and lower for those who have been neglected. That was in your first report. But neglect seems to be the most prevalent form of abuse particularly among younger children, so I just wondered what your comments were about that?

Dr. Jee: [58:20] Right. I think that's an excellent question, and we've thought about this a lot. I think what happens is that the kids who are clearly physically and sexually abused, that it is just more obvious when they first come into care. You know, sometimes it's bruising or there are physical manifestations so everybody's up in arms and trying to get things in place for this child. And while I think neglect is maybe even more insidious because it's so pervasive and harder to detect, those children often have long-standing years of neglect that have created bad problems for them later on in reactive attachment disorder because they never had normal attachment as an infant.

So I think what I would take from this is that while I think it's great that physically and sexually abused children seem to be getting into services at a higher rate than the overall group, all these children have for some reason come to attention because of some report of child abuse and neglect, and I think they're all deserving of some kind of evaluation. And if there are not resources for a full mental health evaluation for everyone, which unfortunately there are not enough resources for that, I think doing some sort of screening or just keeping this in mind as a provider would be best for the children. We don't know what the long-term outcomes are and their adverse health outcomes, but we know from some of the other studies that have been done in adults looking at their traumatic experiences as children that this can cause long-term physical health problems in adults. In the [inaudible] studies that they've looked at the traumatic experiences for young children. So I think the physically and sexually abused children they come to attention, but it doesn't mean that they're necessarily the worst cases long term, that's the children who have been neglected and surely need services too.

Audience Member 8: [1:00:31] I have a follow on question to that. Have you looked to see whether there is an interaction going on in the data between physical and sexual maltreatment and placement type? Cause it may be that those children are more likely to be in foster care, and then those children had more likely access to mental health services.

Dr. Jee: [1:00:51] That's an excellent question, and I don't know. I honestly can't remember if we did that, but I think we should definitely look at that because clearly those are the kids who come in and get the most attention. I think we did at some point look at the issue of reabuse and

whether or not the placement type and type of initial maltreatment had any difference in rates of reabuse, and there were none. So really it looked like there was no difference in terms of children who had been physically, sexually abused or experienced other forms of neglect that they were experiencing reabuse in the same rates. But I should definitely look at that again, I can't remember.

Any other questions? [silence] Great, well thank you so much.

[background discussion]

Dana Schultz: [1:02:38] Hi, this is Dana Shultz from Rand. I'm in our Pittsburgh office, and I was going to talk about the work that we did looking at the relationship between protective factors and outcomes for children investigated for maltreatment.

I wanted to acknowledge my two colleagues, Ameila Haviland, who is our statistician, and Shannah Tharp-Taylor, who is a developmental psychologist, and we worked on this grant collaboratively.

So what we're trying to do is look at the resilience literature and theoretical framework to examine certain protective factors over time for children investigated for maltreatment. Those protective factors that we focused on were social competence, adaptive functioning skills, and the peer relationships. Then we wanted to establish what was the relationship between these protective factors and certain outcomes for this population. The outcomes that we looked at were academic, competence, internalizing, and externalizing behaviors.

So, as we all know, there are different ways to define maltreatment. They tend to be somewhat general but include physical, sexual, emotional maltreatment, neglect, and other kinds of maltreatment. What we do know is that the literature has consistently supported the idea that maltreatment, however it is defined, is linked to negative child outcomes. And these outcomes include things like poor academic performance, higher risk for internalizing and externalizing behaviors among many other problems.

In terms of the outcomes that we're looking at, maltreatment has been found to be associated with each of our outcomes of interest. So for academic competence, we know that maltreated children are more likely to have below-grade-level achievement on test scores, be held back in grades, and to be rated by teachers as not having good work habits. For internalizing behavior, we know that maltreated children tend to have more depression, more social withdrawal problems, some sleep problems. And then for externalizing behavior, at that younger age maltreated children tend to be more aggressive towards peers and adults, and the school-aged children have more disciplinary and behavior problems.

The relationship between maltreatment and outcomes is complicated by what we know... that maltreatment does not consistently lead to severe negative outcomes, and that some maltreated children defy expectations. As Sandy mentioned, resilience is one way to conceptualize what's going on—it being this unmeasured construct that explains how some children manage the negative effects of maltreatment and that it is a dynamic process. And it's something that's not

an individual or a personality trait, but it's something that can be influenced by traits or skills and can be developed or learned.

There are different models that show the mechanism through which resilience works, but the prevailing theory suggests that resilience operates through key protective factors at the individual, family, and community levels. Resilience is often captured by looking at how well children perform on a wide range of outcomes given their exposure to negative life events. In our work, we've separated out the protective factors from outcomes and focus on the potential protective qualities provided by these characteristics. Though we have hypothesized that both maltreatment and protective factors influence outcomes, that higher levels or increases in the protective factor will be related to more positive outcomes.

So I'll tell you how we defined our three protective factors. Social competence being social skills that can be used to control emotions and behavior and to connect with others. Adaptive functioning skills we defined as adaptive skills that can be used to manage daily life, make sense of difficult experiences, adapt to new routines, etc. And then the positive nature of peer relationships: the ability to form and maintain quality friendships with your peers.

So our two primary research questions are: How do the protective factors change over time? And what is the relationship between protective factors and outcomes? I have a couple of slides on the NSCAW, which I don't think we need to pay too much attention to because of the introduction that was given, but I do want to just point out on this slide that in our analyses we used data from waves 1, 3, and 4, and that the measures that we use came from the child interview, the caregiver interview, and some of the details about the maltreatment and the investigation came from the CPS agency worker interview.

For our analysis sample, we set subsets of the data to look only at 3- to 8-year-old children so that left us with 1,748 children. We excluded those who were missing a lot of information from waves 3 and 4 so that dropped us down a little bit, and then we excluded those children who are missing some of our baseline or wave 4 outcome variables. So our final analysis sample was 1,216. So those are the children I'll be talking about as we move forward.

We looked at a variety of demographic and contextual factors that we wanted to account for in our analysis, and they are listed here. And I'll just briefly show you the distributions for each of them. In our analysis sample, the mean age was 5.5. We had slightly more males than females. We had to worry about what [inaudible] non-Hispanic about a quarter Black/non-Hispanic and 20 percent Hispanic. Most of the parents/caregivers were the child's parent. Most of them had more than a high school education. About 44 percent of them had income below \$15,000, and the rest were over that. We also looked at the neighborhood that the child was living in and how the caregiver had rated that in terms of safety with about half of them saying it was safer than other neighborhoods. Then we examined some of the factors related to the caregiver's health and wellness, such as their physical health. About two-thirds of the caregivers said that they were in good physical health. We looked at the caregiver's mental health status in terms of their major depression, and 22 percent of the caregivers in our sample scored as having major depression. Then we also looked at alcohol and drug use as control variables in our models. Then related to

the maltreatment investigation, we wanted to account for the most serious alleged abuse or neglect, the level of harm, and the outcome of the investigation. And you can see where the raw distributions were in our sample for those.

So for the first research question looking at protective factors and how they change over time for this sample--I'll just briefly tell you we use the Social Skills Rating System to measure social competence and that looks at subscales, which involve cooperation, empathy, assertion, self-control, and responsibility. For the adaptive functioning skills, we use the Vineland and the daily living skills part of that. And then for peer relationships we use the loneliness and social dissatisfaction questionnaire.

So when we first looked at how the protective factors or three protective factors developed over time, we looked at the distribution of scores at each wave for the whole analysis sample. What we saw was there is a wide variation in the children's scores on these measures. As a whole, that the sample has lower scores on these measures than non-at-risk sort of normed samples.

We also saw that as a group there is not a lot of change in the distribution of scores over time. So if we looked at the overall mean for waves 1, 3, and 4 that there wasn't a lot of movement for the whole sample in the mean score. We did also look at the distribution of the change in individual protective factors across the waves. We saw that the center of the distribution is near zero, meaning that many of the children had little or no change in scores over time, but that the standard deviation of the individual changes are large. And that told us that there are children who had large increases and decreases in scores over time. The reasons that we were looking at the protective factors over time is because we wanted to account for any changes of them in the model that were related to our second research question. And so what we did was, since we did see that there was...that the standard deviations of the change over time were large that we include that in the model. So you'll see that in our models to predict outcomes, we include both the mean score for the protective factor and what we call the slope, or that standard deviation of the change over time.

So our second research question was: What is this relationship between protective factors and outcomes for children investigated for maltreatment? And we used the CBCL for the externalizing and internalizing outcomes, and we used the Mini-Battery of Achievement to look at reading competence. And that was our outcome measure for the academic competence outcome that we were looking at. We did models in three stages, and in our first set of models we included baseline, child, and demographic variables. Those are the ones that I showed you earlier, and in the second step we added variables related to the investigation into the alleged maltreatment. And then in the final step, we included the mean and the change over time for all three protective factors in the model together.

So what I'm going to show you now is just those final full models. So this is the full model that includes all the demographic and contextual factor control variables as well as the protective factor variables. It shows the association between the protective factors and the odds of being in the normal range for, in this case, externalizing behavior. So what we can see here is that social competence, adaptive functioning skills, and peer relationships are each highly statistically significant and positively associated with being in the normal range for externalizing behavior.

So for example, a 1 standard deviation increase in the mean's social competence score translates into 2.3 times greater odds of being in the normal range for externalizing behavior. You'll also see that for social competence, the slope is also significant—indicating that children with increasing social competence scores over time were also more likely to be in the normal range for externalizing behavior.

For internalizing behavior, we see that children with higher mean levels of social competence were more likely to be in the normal range. The odds ratio there, 2.2, indicates that a 1 standard deviation increase in mean social competence is associated with 2.2 times higher odds of being in the normal range for internalizing behavior. There is, as in the other models, and I don't want to spend too much time on it, but there are some of the demographic and contextual control factors were also either significant or marginal in these models and you can see those there.

For our third outcome we looked at reading, achievement, and competence, and here we see the number and protective factors on the likelihood of being in the normal range for reading. We see that children with higher mean adaptive functioning skills were more likely to be in the normal range. So that's children with mean adaptive functioning skills one standard deviation above others have odds 2.5 times higher of being in the normal range for reading. Then social competence in peer relationships scores were both marginally related to reading scores. With odds of 1.6 and 1.5.

What we found for our primary research question is that, when examined together, the social competence adaptive functioning skills and the peer relationships were all highly significant in the three models. When examined together, social competence consistently predicted positive outcomes. Children with higher levels of social competence were significantly more likely to be in the normal range for both externalizing and internalizing behavior and marginally more likely to be in the normal range for reading. Then for the adaptive functioning skills, children with higher mean scores were significantly more likely to be in the normal range for externalizing behavior and reading competence. Then the positive peer relationships was significantly related to externalizing behavior with higher mean scores positively associated with being in the normal range.

Another thing that we wanted to point out, is that when entered into the models singly, meaning one protective factor at a time, each of the protective factors are positively associated with being in the normal range and significant. Then when we put them all together, you see that social competence emerges as the strongest predictor for our outcomes. Then in terms of protective factors over time, we saw a small but significant change in protective factors over time and at an individual level. Children do experience both positive and negative changes over time in these protective factors.

So by separating out these protective factors from outcomes, the link between the protective factors and future child outcomes and children with higher scores in the protective factor measures had better outcomes and that this may help explain the mechanism through which children exposed to maltreatment fare well. With this better understanding of how the protective factors work, we can contribute to the development of prevention and intervention programs that look to improve those protective factors and kind of foster resilience. We would like to do some

further research to establish this causal link between protective factors and outcomes but we have seen this relationship in the work that we did. So I think that's all.

I'd be happy to answer any questions.

Ms. Supplee: [1:20:18] Hi Dana, my name is Lauren Supplee. I have a question. I've used the SSRS before, and I know some of the items but not all off the top of my head. Do you know or did you look at which items on the social competence are things that might be malleable or are they more trait-like behaviors?

Dr. Schultz: [1:20:38] We didn't specifically look at how different items or even subscales operated, but it would be interesting to go back and look at the different subscales and which ones of those may be modifiable .

Ms. Supplee: [1:20:56] Yeah, I was just thinking about implications for practice... If they are things that are malleable and it is clearly a consistent protective factor then it would be really interesting to explore that.

Dr. Schultz: [1:21:06] Right.

Ted Cross: [1:21:12] This is Ted Cross. I have a question. I'm a little concerned that there is not a really strong conceptual distinction between the protective factors and outcomes. In fact, you can make an argument that some of the things you're calling outcomes could be protective factors against some negative scores or unproductive factors. Lower internalizing scores could be protective against problems with adaptive functioning. I guess what I would like to see is if any of the protective factors actually reduced a relationship of a risk factor to an outcome, and I wondered if you considered or if you've done an analysis like that?

Dr. Schultz: [1:22:19] So do you mean... When we did the three stages of analysis... So in our first stage, we had the demographic child and caregiver factors predicting outcomes, and we added in the maltreatment and investigation factors, and then we added in the protective factors as the third stage.

Dr. Cross: [1:22:45] But did you do any analysis that would look specifically at protective factors as moderators of the effect of risk factors and outcomes?

Dr. Schultz: [1:22:53] No.

Dr. Cross: [1:22:56] That's a direction I would really recommend you might want to go because then you're actually seeing, if you can find statistical evidence of moderation, then you're actually seeing the protectiveness of those factors in action.

Dr. Schultz: [1:23:09] Right. When we were separating out things that were traditionally looked at as possibility of outcomes when people conceptualize resilience, we were trying to look at those protective factors that were potentially modifiable. So we could say, well if these things are

influencing outcomes then maybe that's an area for potential strategies for prevention and intervention.

Dr. Cross: [1:23:41] But, again, it's not clear to me that you've actually got something, that you've got actually two distinct variables versus two different aspects of a broader functioning or well-being variable. So I'd think you'd need to do a little more conceptual work on that.

Dr. Schultz: [1:24:04] OK.

Audience Member 9: [1:24:09] Hi. I just wanted to throw out a citation for you. I was reading in the Scientific American Mind--I think it's the most recent edition--there has been research now that researchers were able to sort of single out a gene that has about, it can predict about 3 to 4 percent of the ability of individuals to cope with stress and anxieties. So I think that would be something interesting if you had time to maybe look at that article. I think that researchers have kind of long held this belief that resiliency has some kind of genetic component, and now that they are able to single out a single gene it may lead your research in further directions.

Dr. Schultz: [1:24:50] OK, thank you.

Dr. Burns: [1:24:56] I have a question you may not be able to answer, but what I'm interested in is whether you have any sense of what proportion of the youth studied are a positive on these major protective factors? I saw some of the earlier numbers but not on these measures.

Dr. Schultz: [1:25:26] The protective factor measures have the normal range and the clinical range as the outcome measures do. So I don't have the distribution. I know, like in the social skills rating system, they have three different levels. And I don't have the distribution, but it is distributed across the range of how they...

Dr. Burns: [1:25:55] Right. What I'm pushing toward, the odds are a help but a sense of the frequency and the normal range on those particular measures and then how do kids distribute along those measures? It looks like they are behaving pretty similarly but putting the conceptually different variables to some extent. So do they cluster? I guess that's what my question really is? Then how much of this population has enough of these that you don't have to worry about?

Dr. Schultz: [1:26:48] Right. Well, I know a little bit about how, on the outcome variables, how our sample compared to the normal example.

Mary Bruce Webb: [1:27:06] There are norms, actually, for the SSRS and for the adaptive functioning scales. I think that would be worth doing.

Dr. Schultz: [1:27:15] Yeah. I don't have it on the tip of my fingertips.

Dr. Burns: [1:27:20] So what percent are in the normative range on each one of those measures, and what's the relationship or correlation matrix look at those measures? They have to be

somewhat different or they would've blown the model up. What combinations of normative range are common and then related to outcomes?

[silence]

Dr. Schultz: [1:28:06] Any other questions?

Ms. Brodowski: [1:28:15] Great. Thank you so much, and I really want to thank all the presenters. There's a lot of information that was shared today, and I think a lot of great questions. In my mind, I'm thinking what are the next steps as well in terms of helping the practitioners in the field use this information and think about the types of services that really should be provided and the level of quality, etc.

We'd love to get your feedback on this webinar, so I know that Jean will be sending out, I believe, a follow up email or everyone who's registered will get a follow up email with, I think, the link to all of the materials that'll get posted to our Child Welfare Information Gateway.

I also wanted to let people know that in April we are hosting another, I think it's going to be a webinar as well on April 23 from 1 – 3 p.m., and the CDC will be presenting on their parenting programs meta analysis that they've just completed and is actually in press right now. I know there's a lot of interest in that information. So we'll make sure to send out that invitation to everyone and [would] love to have you join us again. Also any input on this webinar or plug for any of the other Federal agencies, if you are listening, if you are interested in featuring any of your projects or initiatives just let me know, and we'd be happy to set that up for folks.

Ms. Supplee: [1:29:56] Melissa? I want to take the opportunity to thank the presenters for taking time out of their busy days to come and talk to us about the work they're doing with NSCAW. Definitely keep us informed about publications that come out, and we'd be happy to distribute that information. People on the call who didn't know about NSCAW before and want to learn more, they can email me and I'd be happy to give you the website for the project on OPRE's website and also where the data is housed and you can request access to it at the National Data Archive on Child Abuse and Neglect. I don't know if my mail went out but it is Lauren.Supplee@acf.hhs.gov.

NSCAW information on OPRE's website:

http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/index.html

National Data Archive on Child Abuse and Neglect

<http://www.ndacan.cornell.edu/>