

Family Intensive Treatment (FIT) Outcomes Report

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Abstract

The Family Intensive Treatment (FIT) team model was developed by a group of key behavioral health stakeholders in Florida to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance use disorders. First implemented in 2014, the FIT program was designed to provide parents/guardians timely access to a comprehensive and integrated array of treatment services and supports that (a) promote engagement and retention in treatment, (b) facilitate recovery, and (c) improve parenting capacity, child safety, permanency, and wellbeing. The current evaluation study examined the effect of FIT on child safety, permanency, and parental wellbeing. A longitudinal quasi-experimental design with a two-group comparison using propensity score matching was used. The sample consisted of 3,025 parents/guardians who received FIT intervention and 2,976 child welfare involved parents/guardians who did not receive FIT, but otherwise were similar to the FIT participants. Findings based on four fiscal year cohorts indicated that compared to a group of similar parents/guardians receiving child welfare services, parents/guardians who received FIT were less likely to have new allegations of child maltreatment within six and twelve months after completing the FIT program. There is no significant association between FIT receipt and recurrence of verified (i.e., substantiated) maltreatment: the rates of verified maltreatment were very similar for the parents/guardians in the FIT group and the parents/guardians in the comparison group. Similarly, no significant differences were found when the rates for foster care reentry were examined. Children of parents/guardians who received FIT achieved permanency faster and at a greater rate compared to their counterparts. In addition, participation in the FIT program predicted improvement in parental/guardian emotional protective capacity, overall protective capacity, and showed a positive tendency in improvement of parental/guardian behaviors related to their protective role. Finally, parents/guardians who received FIT demonstrated significant improvements over time in several wellbeing domains including Daily Living Activities, Mental Health and Addiction, and Adult and Adolescent Parenting. Overall, this study provides new data about the effectiveness of the FIT intervention and shows that families benefit across a wide range of areas -- reducing the risk for further adversity among child welfare involved parents/guardians with substance use problems.

Introduction

The Family First Prevention Services Act (FFPSA) was passed into law on February 9, 2018, as part of the Bipartisan Budget Act of 2018 and has several provisions to enhance support for families to help children and youth remain at home, reduce the use of congregate care, and build the capacity of communities to support children and families (Family First Act, 2022). This act challenged states to redesign their child welfare systems, putting the focus on preventing children from entering foster care and when necessary, ensuring that children are cared for in the best, family-like settings when removal is necessary. The Florida Department of Children and Families (DCF) is undergoing a cultural and programmatic shift from a primarily crisis-response agency to a precrisis, prevention agency. The Department is looking at the efficacy of services and ensuring needs are met timely to help families succeed. This includes pre-crisis contact with families and reducing re-entry into crisis.

Parental substance misuse appears to be a major contributing factor for child maltreatment and subsequently to the placement of children in out-of-home care. It is estimated that 29.4 percent of child victims had a caregiver with a drug abuse problem (U.S. DHHS, 2021a), and parental alcohol or drug misuse was identified as a condition of removal for almost 41 percent of all children placed in out-of-home care (U.S. DHHS, 2021b).

Research focusing on substance use disorders among child welfare involved parents has consistently documented various adverse outcomes. Parental substance abuse has been shown to be associated with high risk of placement in out-of-home care (Ghertner, Waters, Radel, & Crouse, 2018), lower reunification rates, (Courtney & Hook, 2012), higher foster care reentry rates (Brook et al., 2010), loss of custody (Grella, Needell, Shi, & Hser, 2009), and child emotional and behavioral problems (Seay & Kohl, 2015; Smith & Wilson, 2016). Considering the number of child welfare involved parents with substance use problems and the negative outcomes associated with this issue, interventions that focus on service provision for child welfare involved parents with substance misuse issues has become a public priority.

Program Description

The Family Intensive Treatment (FIT) model was developed by a group of key behavioral health stakeholders in Florida to provide “intensive team-based, family-focused, comprehensive interventions targeting high-risk families with child welfare involvement due to parental substance use and co-occurring mental health disorders” (Florida Department of Children and Families, 2020, p. 4). The FIT model was first implemented in Florida in 2014 in consecutive phases across the state, and there are currently 23 FIT teams offered by 19 community-based

behavioral health providers subcontracted through Managing Entities. The goals of the FIT program are to provide parents/guardians timely access to a comprehensive and integrated array of treatment services and supports that promote engagement and retention in treatment, support recovery, and improve parenting capacity, child safety, permanency, and wellbeing.

While the guidelines for the model offer service flexibility that is individualized to meet the needs of each parent/guardian and family, the unique feature of the FIT model is the intensive team-based approach that consists of a program manager, behavioral health clinician, case manager, and recovery peer specialist who provide coordinated care for all families. The FIT model includes the following components:

- Comprehensive initial and ongoing assessment
- Individualized treatment planning based on child and parent assessment
- Coordinated specialized services and linkages to community resources
- Multi-disciplinary treatment staffing consisting of the FIT provider, child welfare professionals, parents and guardians, teachers, and other pertinent parties
- Assessment and assistance with basic needs
- Intentional transition and discharge planning with the family and child welfare case management.

FIT program guidelines also require training in and provision of evidence-based and evidence-informed practices to treat substance abuse, mental health, and improve parental capacity -- although it does not mandate that any particular interventions be used.

Purpose of the Evaluation

The purpose of this evaluation is to determine the effectiveness of the FIT model with families involved in the child welfare system experiencing parental/guardian substance use by comparing child welfare outcomes for families who received FIT program services to those of a comparison group who did not receive FIT program services. Specifically, analyses were conducted to expand prior research completed by the University of South Florida (USF) research team (Robst, Armstrong, Yampolskaya, Sowell, & Cruz, 2019) under contract with Florida Department of Children and Families and Casey Family Programs. This report provides results from an expanded research study that examined recurrence of child maltreatment reports, recurrence of verified child maltreatment, permanency outcomes, reentry into out-of-home care, and the outcomes for functional assessments using more recent data. This study includes families enrolled in FIT in fiscal years 2016-17 through 2019-20, and it extended the

follow-up period to 12 months after discharge from the FIT program. Parental demographic characteristics of gender, age, and race/ethnicity were also included in the analyses.

Methods

Evaluation Questions

1. What is the proportion of child maltreatment re-reports within six months of the initial report and within six months of FIT program completion during a specific fiscal year for the individuals who received FIT intervention and those who were in the comparison group?
2. What is the proportion of child maltreatment re-reports within 12 months of the initial report and within 12 months of FIT program completion during a specific fiscal year for the individuals who received FIT intervention and those who were in the comparison group?
3. What is the number and proportion of children that experience verified maltreatment within 6 months of a child's first report of child maltreatment and within six months of FIT program completion if maltreatment was verified?
4. What is the number and proportion of children that experience verified maltreatment within 12 months of a child's first report of child maltreatment and within 12 months of FIT program completion if maltreatment was verified?
5. What is the number and proportion of children who re-enter out-of-home care within 12 months of their most recent discharge from out-of-home care?
6. What is the number and proportion of children who achieved permanency (i.e., reunification, guardianship, placement with relatives, and adoption) including reunification?
7. What is the effect of receiving FIT on caregiver protective capacity?
8. Is there a positive change in parenting and child-rearing attitudes after receiving FIT?
9. Is there a positive change in daily functioning after receiving FIT?
10. Is there a positive change in caregiver functioning, including substance misuse and criminality, community living skills, interpersonal skills, mood, psychological state, and health and physical functioning after receiving FIT?

Population of Focus/Sample

The intervention group consists of child welfare involved parents/guardians diagnosed with substance use disorder who have at least one child between the ages of 0 and 10 years old and

who at the time of the referral to FIT were determined to be “unsafe” as per Florida’s Child Welfare Practice Model and in need of child welfare case management. In the case of a child removal, the family must have a child welfare case management plan with reunification as a permanency goal. If the child is unsafe and remains in the home the goal should be to maintain and strengthen the family’s ability to care for that child.

Evaluation Design

A longitudinal quasi-experimental design with a two-group comparison using propensity score matching was used in this evaluation study. The two groups included the intervention group (i.e., FIT) and the comparison group (i.e., child welfare involved parents/guardians who did not receive the FIT intervention). The propensity score matching was used to control for initial differences across multiple background characteristics and baseline variables (Rosenbaum & Rubin, 1984). The propensity score technique is used to achieve group equivalence when participants are initially assigned to different conditions as well as in observational studies when individuals cannot be randomly assigned to different conditions. The propensity score matching was utilized for several reasons: (a) randomization was not possible because intervention was implemented for all qualified individuals, (b) participants in the FIT intervention substantially differ from other child welfare involved parents/guardians on a number of characteristics, and (c) the need to have an equivalent comparison group to adequately assess examined outcomes.

Propensity scoring yields a single composite score, and therefore allows for a sensible estimation of treatment vs. control effects (McCaffrey, Ridgeway, & Rand, 2004; Rosenbaum & Rubin, 1984). We followed the suggestion made by Rubin and Thomas (1996) and Rubin (1997) advising that all variables presumptively related to an outcome, even if weakly so, should be included in the equation. Because sociodemographic characteristics are believed to be among the most important covariates that might affect outcomes, race/ethnicity, gender, and age were included in the calculation of the propensity scores. In addition, type of child maltreatment, primary drug of choice, presence of mental health diagnosis, and the county where the child protection investigation took place were included as covariates. The aim of this matching was to control for observed differences in child welfare involved parental characteristics.

The propensity score was calculated using logistic regression to obtain the predicted probability of being in the intervention group (Rosenbaum & Rubin, 1984). As a result, each parent/guardian in the database had an estimated probability of being in the intervention group (i.e., FIT). After the propensity score was calculated, cases were matched using the nearest neighbor technique, in which the propensity score in the comparison group closest to the

propensity score in the intervention group (i.e., FIT) was selected (Dehejia & Wahba, 2002). After matching was completed, the intervention and the comparison groups were checked for balance on all parent/guardian characteristics included in the calculation of propensity score. No significant differences between groups were found when the groups were examined on each of the covariates (i.e., parent/guardian characteristics) included in the propensity score. Four successive cohorts were examined including cases investigated during state fiscal years 2016-17, 2017-18, 2018-19, and 2019-20. Both FIT participants and child welfare involved parents/guardians selected in the comparison group were followed up until June 30, 2021, to allow for a 12-month follow-up period – with a special analysis tracking child outcomes at 6 and 12 months after completion of the FIT program.

Data Sources

Three data sources were utilized including (a) the Florida Safe Families Network (FSFN), (b) the Family Intensive Treatment (FIT) database, and (c) the Financial and Services Accountability Management System (FASAMS). The FIT database contains records for each parent/guardian including the date of enrollment in the FIT program, the completion status, demographic characteristics, parental assessment and functioning, and substance use or mental health diagnosis. The FSFN database contains records for each child and the alleged perpetrator in the child welfare system, information about child maltreatment reports, parent/guardian and child demographics, the findings of child protective investigations, dates of children's entry into out-of-home care, caregiver protective capacity assessment, and dates of discharge. Finally, the FASAMS database contains service records and behavioral health diagnoses for individuals receiving Florida DCF funded mental health and substance abuse services.

Predictor Variables

The predictor variables or covariates included the parent's/guardian's demographic characteristics and participation in the FIT program. A description of each one follows:

Participation in FIT. As is typical in evaluation research, the analysis uses an intent-to-treat approach. Thus, the analysis uses all available data. Therefore, participation in the FIT program was defined as person's enrollment in the FIT program regardless of whether the parent/guardian completed treatment or was disengaged from treatment. Participation in FIT was coded as 1 and the comparison group was coded as 0.

Parental demographic characteristics. Demographic characteristics included gender, age, and race/ethnicity. Gender consisted of two categories – male and female. Age was a

continuous variable measured at the time of enrollment in the FIT program for FIT participants or at the time when the first maltreatment report was received. Race/or ethnicity included the following categories: White, Black, Multiracial, and Hispanic. Other categories were excluded from the analysis because there were very few cases available for obtaining stable and reliable estimates.

Part I: Methods and Findings for the Full Sample Intent to Treat Analysis

Overview

This report includes two analyses of the quasi-experimental study with a comparison group. The first analysis includes all of the families that began the FIT program even if they did not fully complete the program. FIT recipients and a matched sample of comparison group of parents/guardians were followed for 6 and 12 months after FIT intake. The second analysis focuses on a sub-set of families that completed the FIT program. In this analysis FIT recipients and a matched sample of comparison group of caregivers were followed for 6 and 12 months *after* FIT program completion.

Measures (Outcomes)

Several safety indicators were calculated and examined, including rates of repeated child maltreatment reports, rates of recurrence of verified maltreatment, and rate of reentry into out-of-home care. Timeframes for child safety and permanency outcomes were selected and based on the Child and Family Services Reviews (CFSR) national data indicators (U.S. DHHS, 2022).

Child maltreatment re-reports within six months. This indicator was based on entry cohorts, that is, all children who were brought in contact with the child welfare system and subsequently investigated for alleged child maltreatment. For the FIT group, child maltreatment re-report was defined as a subsequent investigated child maltreatment report within six months after the enrollment in the FIT program, regardless of the disposition. For the comparison group, child maltreatment re-report was defined as a second investigated child maltreatment report within six months of the initial report regardless of the disposition.

Child maltreatment re-reports within 12 months. This indicator was based on entry cohorts, that is, all parents/guardians who were reported and subsequently investigated for alleged child maltreatment. For the FIT group, child maltreatment re-report was defined as a subsequent investigated child maltreatment report within 12 months after the enrollment in the FIT program -- regardless of the disposition. For the comparison group, child maltreatment re-

report was defined as a second investigated child maltreatment report within 12 months of the initial report regardless of the disposition.

Recurrence of verified child maltreatment within six months. This indicator was based on entry cohorts, that is, all parents/guardians who were reported, subsequently investigated for alleged child maltreatment, and as a result of the child protection investigation, child maltreatment was found verified. For the FIT group, recurrence of maltreatment was defined as subsequent verified child maltreatment report within six months after the enrollment in the FIT program. For the comparison group, recurrence of maltreatment was defined as a second incident of verified maltreatment within six months of a child's first verified maltreatment incident. Only children with "verified" maltreatment (i.e., when the protective investigation resulted in a verified finding of abuse, neglect, or threatened harm) were included in the analysis. The first and second episodes of maltreatment were selected based on the dates the reports of child maltreatment were received.

Recurrence of verified child maltreatment within 12 months. This indicator was based on entry cohorts, that is, all parents/guardians who were reported, subsequently investigated for alleged child maltreatment, and as a result of the child protection investigation, child maltreatment was found verified. For the FIT group, recurrence of maltreatment was defined as subsequent verified child maltreatment report within 12 months after the enrollment in the FIT program. For the comparison group, recurrence of maltreatment was defined as a second incident of verified maltreatment within 12 months of a child's first verified maltreatment incident. Only children with "verified" maltreatment (i.e., when the protective investigation resulted in a verified finding of abuse, neglect, or threatened harm) were included in the analysis. The first and second episodes of maltreatment were selected based on the dates the reports of child maltreatment were received.

Reentry into out-of-home care. This indicator was defined as reentry into out-of-home care within 12 months of their most recent discharge. This measure is based on the exit cohort. An exit cohort is defined as all children who exited out-of-home care during a certain time period as indicated by a *Discharge Date* in FSFN. Children were followed for 12 months from the date of discharge from out-of-home care to determine whether they were subsequently placed in out-of-home care as indicated by a new (second) *Removal Date* in FSFN.

Permanency. The number and proportion of all children exiting out-of-home care for permanency reasons within 12 months of the latest removal. This measure is based on an entry cohort, that is, all children who were placed in out-of-home care during a specific fiscal year as indicated by the "removal date" in FSFN. Children were followed for 12 months from the date of

removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved permanency. Permanency is defined as discharge from out-of-home care to a permanent home for the following reasons as indicated in FSFN: (a) reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker, (b) permanent guardianship (i.e., long-term custody or guardianship) with a relative or non-relative, and (c) adoption finalized, that is, when the Court enters the verbal order finalizing the adoption.

Reunification with Original Caregivers. This measure is based on entry cohort. An entry cohort is defined as all children who were placed in out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker. Reunification is identified based on one of the reasons for discharge as indicated in FSFN.

Caregiver Protective Capacities. This measure was developed as a part of the Safety Decision Making Methodology by Florida DCF in consultation with the National Resource Center for Child Protective Services (NRCCPS), ACTION for Child Protection, and the Children's Research Center. Caregiver Protective Capacities (CPC) are determined during the Family Functioning Assessment-Initial (FFA-I) that is completed by the Child Protection Investigator and the Family Functioning Assessment-Ongoing (FFA-O) that is completed when the case has been transferred to the Community Based Care agency for case management supervision. Policy states that the Dependency Case Manager will update the FFA-O every 90 days, at a minimum, or when circumstances warrant a review and possible revision. Based on the information in the FFA-I and FFA-O, the Child Protection Investigator and the Dependency Case Manager will rate the CPCs for each caregiver in the household. The ratings of CPCs are used to systematically identify ones that need to be the focus of case plan outcomes and interventions.

- An "A" or "B" rating for any indicator reflects that a parent/legal guardian is doing well in that area.
- A "C" or "D" rating reflects that a parent/legal guardian is not doing well and requires attention.

The following are the common criteria applied to each individual rating:

- A = Excellent. Caregiver demonstrates exceptional ability in this area.

- B = Acceptable. Caregiver demonstrates average ability in this area.
- C = Some Attention Needed. Caregiver demonstrates some need for increased support in this area.
- D = Intensive Support Needed. Caregiver demonstrates need for intensive support in this area.

The CPC consists of three capacity categories - behavioral, cognitive, and emotional which are comprised of a total of 19 specific capacities. The behavioral protective capacity category consists of the following capacities: demonstrates impulse control, takes action, sets aside own needs for child, demonstrates adequate skills, adaptive as a caregiver, and history of protecting. The cognitive protective capacity category consists of the following capacities: self-awareness, intellectually able, recognizes and understands threats, recognizes the child's needs, understands protective role, and plans and articulates plans for protection. The emotional protective capacity category consists of the following capacities: able to meet own emotional needs, is resilient, is tolerant, expresses love, empathy, and sensitivity to the child, is stable and able to intervene, is positively attached to the child, and is supportive and aligned with the child.

The total score on the CPC measure and each of the three capacity categories were included in the analysis as separate variables. For FIT parents, the CPC scores were obtained from the FFA-O. The CPCs from the FFA-O assessment that was closest to the FIT enrollment date were used as the baseline measure, while the FFA-O assessment closest to the discharge date was used as the ending measure. For parents in the comparison group, the first FFA-O was used as a baseline and the subsequent FFA-O was used as a post-test.

Functional Assessment of Mental Health and Addiction (FAMHA) score. The FAMHA is a 44-item clinician-assessment tool designed to assess functioning in six domains: substance misuse and criminality, community living skills, interpersonal skills, mood, psychological state, and health and physical functioning (Anderson & Bellfield, 1999). Ratings range from 1 to 7 for each question with the total score equal to the sum of all ratings divided by 3.08. A higher score indicates greater functioning. The assessment was performed within 30 days of enrollment into the FIT program and at discharge. This measure was not administered to the comparison group.

Adult Adolescent Parenting Inventory-2 (AAPI-2) score. The AAPI-2 is a 40-question assessment tool designed to assess parenting and child-rearing attitudes (Bavolek & Keene, 2005). The AAPI-2 encompasses five different types of behaviors, including parental expectations, parental lack of empathy towards children's needs, use of corporal punishment as a means of discipline, parent-child family responsibilities, and children's power and independence. Higher scores indicate more optimal attitudes. The assessment was performed

within 30 days of enrollment and at discharge. This measure was not administered to the comparison group.

Daily Living Activities (DLA) score. The DLA-20 Functional Assessment is a comprehensive functional assessment and outcome measurement tool for behavioral health providers to measure their clients' level of functioning in daily living activities that can be impacted by mental illness or disability (Scott & Presmanes, 2001).. It assesses the current behavior in 20 activities of daily living considering 10 areas: health practices, household stability, communication, safety, managing time, nutrition, relationships, alcohol and drug use, sexual health and behavior, and personal care and hygiene. The behaviors are ranked by comparing them to qualifiers on a scale from 1 to 7 to determine areas of success as well as areas of concern. This measure was not administered to the comparison group.

Data Analysis

Several analytic techniques were utilized. First, descriptive statistics were used to detect data input errors, outliers, missing data patterns, and to describe the distributions for each measured variable. Second, to examine time to event outcomes, such as time to reunification, Cox regression analysis (Cox, 1972) was used. Cox regression is a type of event history analysis that is used extensively in outcomes research because of its ability to simultaneously examine both the risk of an event occurring and potential deferential effects related to the timing of that event (Cox, 1972). The major advantage of using Cox proportional hazards modeling in this study is that it utilizes information about parents who experienced an event (e.g., recurrence of maltreatment) and those who did not experience the event of interest or did not have another child maltreatment report (i.e., censored observations). To facilitate model interpretation, odds ratios were used to assess the magnitude of the effect of each predictor on time to the event of interest. To examine the effect of FIT on continuous outcomes (e.g., total score on Caregiver Protective Capacity measure), multiple linear regression was used. Finally, to examine the difference between the mean score at pre-test and the mean score at post-test, a paired-samples t-test was conducted. All analyses were conducted using IBM SPSS Statistics (Version 27), a statistical software platform.

Part 1: Study Findings

Before conducting propensity score matching, 3,041 parents/guardians were identified as being enrolled and having received the FIT program during fiscal years 2016-17, 2017-18, 2018-19, and 2019-20. There were 113,573 caregivers who were served as potential participants in the comparison group. The characteristics of child welfare involved

parents/guardians who received the FIT intervention and their counterparts who did not receive the intervention are shown in Table 1.

Table 1

Descriptive Statistics for FIT and Comparison Samples at Baseline Before Propensity Score Matching

Baseline Characteristic*	FIT				Comparison Group			
	<i>n</i>	%	<i>M</i>	<i>SD</i>	<i>n</i>	%	<i>M</i>	<i>SD</i>
Demographics								
Age (in years)	3,041		32.7	7.30	108,994		34.2	9.62
Females	2,242	73.7			56,055	74.5		
White	2,424	79.7			68,497	69.1		
Black	560	18.4			29,272	29.5		
Hispanic	300	9.9			7,275	6.6		
Multiracial	41	1.3			736	0.7		
Type of child maltreatment								
Sexual abuse	40	1.3			9,307	8.4		
Physical abuse	214	7.0			16,132	14.6		
Neglect	1,467	48.2			45,407	41.1		
Emotional abuse	33	1.1			2,170	2.0		
Domestic violence	931	30.6			45,364	41.0		
Threatened harm	330	10.9			9,084	8.2		
Loss of a caregiver	89	2.9			3,835	3.5		
Substance use disorder								
Cocaine	630	20.7			703	1.2		
Stimulant	670	22.0			877	1.5		
Opioid	1,100	36.2			2,401	4.1		
Cannabis	997	32.8			1,399	2.4		
Alcohol	695	22.9			1,390	2.4		
Mental health disorders								
Mood disorder	859	28.3			3,308	5.6		
Anxiety disorder	445	14.6			2,595	4.4		
Personality disorder	15	0.5			77	0.1		
Other mental health disorder	50	1.6			308	0.5		

Note. *County was included as one of the baseline characteristics but was omitted from this table for purposes of legibility.

After propensity score matching, there were 3,025 parents/guardians (unduplicated counts) who were enrolled in and received the FIT program during fiscal years 2016-17, 2017-18, 2018-19, and 2019-20, for whom a match was found. If two parents of the same child were enrolled in the FIT program, one parent/guardian was randomly selected to avoid non-independence of

observations. As a result of propensity score matching, 2,976 child welfare involved parents/guardians who did not receive FIT, but otherwise were similar to the FIT participants, were selected for the comparison group. Descriptive statistics were used to examine the obtained sample and compare parent or guardian/case characteristics for both groups. As shown in Table 2, these analyses revealed that the majority of the study sample were females (approximately 74 percent) and White (approximately 80 percent). The average age of the participants was approximately 32 years.

Table 2 also presents the distribution of parent or guardian/case characteristics at the time they were either enrolled in the FIT program or were brought in contact with the child welfare system for the first time during a specific fiscal year. A substantial proportion (48 percent for the intervention group and 42 percent for the comparison group) of these parents/guardians were investigated by the child protection system for child neglect. Approximately 30 percent of the parents/guardians in each group had a history of domestic violence. A substantial proportion of parents/guardians in both groups used opioids (36 percent in the intervention group and 31 percent in the comparison group), followed by cocaine and stimulants (approximately 21 percent). In addition, mood disorder was the most prevalent mental health diagnosis, with one fourth of the sample having this diagnosis. Smaller proportions of parents/guardians were investigated for sexual abuse (approximately 1.5 percent) or emotional abuse (approximately 1 percent) and were diagnosed with personality disorder (less than 1 percent).

Table 2

Descriptive Statistics for FIT and Comparison Samples at Baseline After Propensity Score Matching

Baseline Characteristic*	FIT				Comparison Group			
	<i>n</i>	%	<i>M</i>	<i>SD</i>	<i>n</i>	%	<i>M</i>	<i>SD</i>
Demographics								
Age (in years)	3,025		32.7	7.30	2,976		31.7	7.27
Females	2,227	73.6			2,218	74.5		
White	2,411	79.7			2,417	81.2		
Black	557	18.4			491	16.5		
Hispanic	293	9.7			284	9.5		
Multiracial	41	1.4			30	1.0		
Type of child maltreatment								
Sexual abuse	40	1.3			55	1.8		
Physical abuse	214	7.1			272	9.1		
Neglect	1,462	48.3			1,253	42.1		
Emotional abuse	33	1.1			37	1.2		

Baseline Characteristic*	FIT				Comparison Group			
	<i>n</i>	%	<i>M</i>	<i>SD</i>	<i>n</i>	%	<i>M</i>	<i>SD</i>
Domestic violence	927	30.6			866	29.1		
Threatened harm	329	10.9			377	12.7		
Loss of a caregiver	89	2.9			97	3.3		
Substance use disorder								
Cocaine	626	20.7			620	21.7		
Stimulant	669	22.1			622	20.9		
Opioid	1,091	36.1			916	30.8		
Cannabis	992	32.8			605	20.3		
Alcohol	688	22.7			250	8.7		
Mental health disorders								
Mood disorder	853	28.2			740	24.9		
Anxiety disorder	445	14.7			496	16.7		
Personality disorder	15	0.5			11	0.4		
Other mental health disorder	50	1.7			55	1.9		

Note. *County was included as one of the baseline characteristics but was omitted from this table for purposes of legibility.

Child maltreatment re-reports within six months. Approximately 17 percent of parents/guardians in the FIT intervention group and approximately 24 percent of parents/guardians in the comparison group were reported for alleged child maltreatment for the second time within six months of the initial child maltreatment report (see Table 3). Both bivariate and multivariate Cox regression analyses were conducted to examine the effect of receiving FIT on the rates of child maltreatment re-reports within six months. The results of both bivariate Cox regression analysis and Cox regression analysis, where parent/guardian demographic characteristics were included, indicated that there is a statistically significant difference (see Table A.1 and Table A.2). Parents/guardians who received the FIT intervention were significantly less likely to have a subsequent child maltreatment report compared to their counterparts in the comparison group. In particular, individuals who did not participate in the FIT program increase the odds of a second report within six months by 45 percent. No parent/guardian demographic characteristics were associated with the child maltreatment re-reports within six months.

Child maltreatment re-reports within 12 months. Approximately 27 percent of parents/guardians in the FIT intervention group and approximately 35 percent of parents/guardians in the comparison group were reported for alleged child maltreatment for the second time within the 12 months of the initial child maltreatment report (see Table 3). Both bivariate and multivariate Cox regression analyses were conducted to examine the effect of

receiving FIT on the rates of child maltreatment re-reports within 12 months. The results of both bivariate Cox regression analysis and Cox regression analysis, where parent/guardian demographic characteristics were included, indicated that there is a statistically significant difference (see Table A.3 and Table A.4). Parents/guardians who received the FIT intervention were significantly less likely to have a subsequent child maltreatment report within 12 months of the initial event compared to their counterparts in the comparison group. Thus, parents/guardians who did not participate in the FIT program increase their odds of a second report within 12 months by 33 percent. When the effect of parent/guardian demographic characteristics was examined, White race was significantly associated with child maltreatment re-reports. Specifically, parents/guardians who were White were 50 percent more likely to have a subsequent child maltreatment report within 12 months after the initial child maltreatment investigation (see Table A.4).

Table 3

Rates of Child Maltreatment Re-reports within 6 and 12 months for FIT and Comparison Group Children (N = 6,001)

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Maltreatment re-reports within 6 months	510	16.9	716	24.1
Maltreatment re-reports within 12 months	827	27.3	1,026	34.5

Note. *n* = 3,025 (FIT); *n* = 2,976 (comparison group).

Recurrence of verified child maltreatment within six months. Rates of recurrence of verified child maltreatment within six months after the initial verified maltreatment were similar for both groups. Approximately 4 percent of parents/guardians in the intervention and comparison groups experienced recurrence of child maltreatment within six months of the initial incident (see Table 4). When the effect of receiving FIT on recurrence of maltreatment was examined, the results of Cox regression analysis indicated no statistically significant difference between the groups (see Table A.5). Participants who received FIT were no more or less likely to experience recurrence of verified child maltreatment within six months after the initial event compared to their counterparts who did not receive FIT. No parent/guardian demographic characteristics were associated with recurrence of verified child maltreatment within six months (see Table A.6).

Recurrence of verified child maltreatment within 12 months. Rates of recurrence of verified child maltreatment within 12 months after the initial verified maltreatment were similar for both groups. Approximately 6.9 percent of parents/guardians in the intervention group and 6.4 percent of parents/guardians in the comparison group experienced recurrence of child maltreatment within 12 months of the initial incident (see Table 4). When the effect of receiving FIT on recurrence of child maltreatment was examined, the results of Cox regression analysis indicated no statistically significant difference between the groups (see Table A.7 and Table A.8). Participants who received FIT were no more or less likely to experience recurrence of verified child maltreatment within 12 months after the initial event compared to their counterparts who did not receive FIT. No parent/guardian demographic characteristics were associated with recurrence of verified child maltreatment within 12 months (see Table A.8).

Table 4

Rates of Verified Child Maltreatment Recurrence Within 6 and 12 months for FIT and Comparison Group Children

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Child maltreatment recurrence within 6 months	129	4.3	120	4.0
Child maltreatment recurrence within 12 months	209	6.9	191	6.4

Note. *n* = 3,025 (FIT); *n* = 2976 (comparison group).

Reentry into out-of-home care. There were 8.6 percent of parents/guardians in the FIT group whose children reentered out-of-home care within 12 months after discharge from child welfare out-of-home placement. The proportion of children who reentered out-of-home care in the comparison group was smaller – 4.6 percent (see Table 5). However, the results of the Cox regression analysis indicated that there is no significant difference between the groups (see Table A.9). When the effect of parent/guardian demographic characteristics was examined, age was found to be significantly associated with reentry into out-of-home care. That is, younger parents/guardians were more likely to have children who were placed in out-of-home care after discharge. Specifically, an increase in year of age would decrease the odds of re-entry by 3 percent. (see Table A.10).

Table 5*Rates of Reentry into Out-of-Home Care for FIT and Comparison Group Children*

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Reentry into out-of-home care	261	8.6	138	4.6

Note. *n* = 3,025 (FIT); *n* = 2976 (comparison group).

Permanency. Children of parents/guardians who received FIT achieved permanency faster and at a greater rate compared to their counterparts. As shown in Table 6, there were 25.2 percent of parents/guardians in the FIT group whose children exited out-of-home care for permanency reasons within 12 months after removal. The proportion of children who achieved permanency within 12 months after initial removal in the comparison group was smaller – 22.5 percent (see Table 6). The results of Cox regression analysis indicated that receiving FIT had a significant positive effect on achieving timely permanency. Specifically, bivariate analysis indicated that children of parents/guardians who received FIT intervention were 15 percent more likely to achieve timely permanency compared to the children of parents/guardians who did not receive this intervention (see Table A.11). The results of multivariate analysis confirmed this finding, that is, controlling for parent/guardian demographic characteristics the effect of receiving FIT remained the same (see Table A.12).

Table 6*The Proportion of Children Who Achieved Permanency for FIT and Comparison Group of Children*

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Exit from out-of-home care for permanency reasons	555	25.2	398	22.5

Note. *n* = 2,205 (FIT); *n* = 1,772 (comparison group).

Reunification with original caregiver. When the proportions of reunified children were compared between the FIT group and the comparison group, no significant difference was observed. There were 15.8 percent of children whose parents/guardians received FIT intervention and 15.7 percent of children whose parents/guardians did not receive such intervention (see Table 7). Results of both bivariate and multivariate Cox regression analyses

confirmed that there was no significant effect of FIT on reunification within 12 months of the latest removal (see Tables A.13 and Table A.14).

Table 7

The Proportion of Children Who Were Reunified with Their Original Caregivers for FIT and Comparison Group of Children

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Exit from out-of-home care for reunification reason	349	15.8	278	15.7

Note. *n* = 2,205 (FIT); *n* = 1,772 (comparison group).

Caregiver Protective Capacities – Emotional Subscale. To examine the association between FIT and the score on the emotional subscale of the Caregiver Protective Capacity (CPC) measure, multiple linear regression was conducted. Because the score on the emotional subscale at pre-assessment was not included in the propensity score matching, this score was included in the model to control for potential initial differences between the groups. The results of multiple linear regression indicated that even controlling for parent/guardian demographic characteristics and initial differences between the groups on the score of the emotional subscale, parents/guardians in the FIT group have a higher score at second assessment conducted at the date close to the discharge date from the program (see Table A.15).

Caregiver Protective Capacities – Behavioral Subscale. Although no statistically significant difference was found when the mean scores on the behavioral subscale of the CPC for the FIT group and comparison group were examined, the *p* value (i.e., *p* = .056) indicated that the effect of FIT approached statistical significance (see Table A.16). Results also have shown that higher scores on the behavioral subscale at the baseline assessment were associated with higher scores at the subsequent assessment.

Caregiver Protective Capacities – Cognitive Subscale. When the effect of receiving FIT on the cognitive subscale was examined, no significant effect of FIT was observed. As might be expected, higher scores on the cognitive subscale at the baseline assessment were associated with higher scores at the subsequent assessment (see Table A.17).

Caregiver Protective Capacities – Total score. When all caregiver demographic characteristics and the initial total score on CPC were included in the multiple linear regression analysis model, FIT were significantly associated with the total score on CPC at post-

assessment. A significant positive association between FIT and a higher total score on the CPC suggested that parents/guardians, who were in the FIT program, significantly improved their overall caregiver protective capacity (see Table A.18). Similar to the associations between FIT and the subscales of the CPC, a higher total score at baseline was associated with a higher total score on CPC at subsequent assessment.

Functional Assessment of Mental Health and Addiction (FAMHA) score. Because this measure was administered to the FIT recipients only, no group comparison could be done. Therefore, the score on FAMHA at baseline was compared to the score on FAMHA at discharge. The results of the paired-samples t-test demonstrated that there was a significant increase in the total score on FAMHA indicating that parents/guardians' functioning in multiple domains significantly improved over time (see Table A.19).

Adult Adolescent Parenting Inventory-2 (AAPI-2) score. This measure also was administered only to parents/guardians who received FIT. Therefore, a group comparison was not available. The comparison was done within the FIT group. The total score at baseline was compared to the total score at the subsequent assessment. The results of the paired-samples t-test revealed a significant increase in the total score on AAPI-2 (see Table A.20). This suggests that parents/guardians' optimal attitudes including attitudes toward expectations of children, empathy towards children's needs, use of corporal punishment as a means of discipline, parent-child roles, and children's power and independence significantly improved over time.

Daily Living Activities (DLA). Because this measure was administered to the FIT recipients only, no group comparison could be done. Therefore, the score on DLA at baseline was compared to the score on DLA at discharge. The results of the paired-samples t-test revealed a significant increase in the total score on DLA (see Table A.21). This suggests that caregiver level of functioning in daily living activities significantly improved over time.

Part I: Discussion of the Study Analysis

The results of the evaluation of the FIT program are mostly supportive of the FIT intervention. Findings based on the four cohorts (SFY 2016-17, 2017-18, 2018-19, and 2019-20) indicated that compared to a group of similar parents/guardians receiving child welfare services, parents/guardians who received FIT were less likely to have new allegations of maltreatment within six months of the initial incident and to be reported for child maltreatment for the second time within 12 months after the first report. Findings also indicated that there is no significant association between FIT receipt and recurrence of verified maltreatment, and the rates of verified maltreatment were very similar for the parents/guardians in the FIT group and

parents/guardians in the comparison group. Similarly, no significant differences were found when the rates for reentry were examined. One possible explanation for this finding is that the comparison group was created by using propensity score matching; therefore, the groups could be equated only based on observable available data elements. There can be other important characteristics that were not included in the analyses that affect FIT participants' outcomes in a significant way but cannot be controlled statistically due to the lack of this information.

This evaluation study has shown that receiving FIT was associated with better permanency outcomes. Although no significant difference was found when the effect of FIT intervention on timely reunification was examined, children, whose parents/guardians participated in the FIT program, were more likely to achieve timely permanency outcomes.

Consistent with the previous study that focused on the evaluation of the FIT intervention, this evaluation has shown that receiving FIT has a significant effect on improvement of caregiver protective capacity (Robst, Armstrong, Yampolskaya, Sowell, & Cruz, 2019). More specifically, participation in the FIT program predicted improvement in parental emotional protective capacity, overall protective capacity, and showed a positive tendency in improvement of parental behaviors related to their protective role.

Regarding the assessments that were conducted only on individuals who received the FIT intervention including Functional Assessment of Mental Health and Addiction, assessment of Daily Living Activities, and the assessment based on Adult Adolescent Parenting Inventory, parents/guardians demonstrated significant improvements over time in all assessed domains.

Overall, this study lends support for the effectiveness of the FIT intervention. Although the effect of the FIT program on different outcomes varies, receiving FIT does seem to help families in a wide range of issues and substantially reduces the risk for further adversity among child welfare involved parents with substance use issues.

Limitations of the study should be noted. First, the study relies on administrative data. Therefore, validity of the records and reliability of reporting across agencies are limited by the quality and consistency of the data entry. Second, this study was limited by the use of outcome measures available via administrative data sets. For example, psychometric validation data to establish the factor analysis structure and test-retest reliability of the CPC assessment has not yet been conducted. Third, a quasi-experimental design was utilized, and while it allows for controlling a great number of parent/guardian characteristics, in contrast to an experimental design with random assignment to the intervention and the comparison group, it does not permit to control for unobservable characteristics that potentially can affect the outcomes. Finally, the findings do not account for the effects of the FIT intervention on various subgroups of

parents/guardians. There may be discrete, identifiable subgroups of individuals who received FIT and for whom the participation in the FIT program has a differential effect. In addition, not all parents could be found in the FASAMS data set and therefore, information about these parents' mental health and substance use diagnoses was not available.

The findings from this study support the importance of providing intensive services for child welfare involved families experiencing substance use issues. It is also important to place an increased emphasis on keeping families engaged in services to ensure service completion. Keeping parents/caregivers diagnosed with a substance use disorder involved in treatment may help improve family functioning and child welfare outcomes. Overall, given the overwhelming evidence of case severity when child maltreatment is combined with substance abuse issues, FIT and other parent/caregiver support services play a major role in both child safety and family well-being.

Part II: Outcomes Analysis of Families Who Completed FIT with Follow-Up 6 and 12 Months After Completion of FIT

Following new FFPSA guidelines, the outcomes for the participants in the program or an intervention should be measured after the intervention ends. Therefore, a second phase of analysis was conducted to assess the effect of FIT on child welfare outcomes with a follow-up period that began after a parent completed the FIT program, and the outcome measures were re-calculated to meet the FFPSA requirements. For these analyses, the intervention group (i.e., FIT) was re-defined and re-created based on only those participants who successfully completed the program. Participants who successfully completed the program were defined as those who completed the treatment as indicated by the "reason for discharge" variable in the FIT database. The comparison group included child welfare involved parents who had similar demographic and behavioral health characteristics but who did not receive the FIT intervention.

Measures (Outcomes)

Several safety indicators were calculated and examined, including rates of repeated child maltreatment reports, rates of recurrence of verified maltreatment, and rate of reentry into out-of-home care. Timeframes for child safety and permanency outcomes were selected and based on the CFSR national data indicators (U.S. DHHS, 2022). Following the FFPSA requirements, all outcomes for the FIT group were measured after the intervention ended, that is after discharge from the FIT program.

Child maltreatment re-reports within six months. This indicator was based on entry cohorts, that is, all children who were brought in contact with the child welfare system and subsequently investigated for alleged child maltreatment. For the FIT group, the child maltreatment report and subsequent re-reports were examined within six months after successful completion of the program. Thus, child maltreatment re-report was defined as a subsequent investigated child maltreatment report within six months after the discharge from the FIT program, regardless of the disposition. For the comparison group, child maltreatment re-report was defined as a second investigated child maltreatment report within six months of the initial report, regardless of the disposition.

Child maltreatment re-reports within 12 months. This indicator was based on entry cohorts, that is, all parents who were reported and subsequently investigated for alleged child maltreatment. For the FIT group, the child maltreatment report and subsequent re-reports were examined within twelve months after successful completion of the program. Thus, child maltreatment re-report was defined as a subsequent investigated child maltreatment report within 12 months after the discharge from the FIT program, regardless of the disposition. For the comparison group, child maltreatment re-report was defined as a second investigated child maltreatment report within 12 months of the initial report, regardless of the disposition.

Recurrence of verified child maltreatment within six months. This indicator was based on entry cohorts, that is, all parents who were reported, subsequently investigated for alleged child maltreatment, and as a result of the child protection investigation, child maltreatment was found verified. For the FIT group, child maltreatment reports and subsequently re-reports were examined after successful completion of the program. Thus, recurrence of maltreatment was defined as a subsequent verified child maltreatment report within six months after the discharge from the FIT program. For the comparison group, recurrence of maltreatment was defined as a second incident of verified maltreatment within six months of a child's first verified maltreatment incident. Only children with "verified" maltreatment (i.e., when the protective investigation resulted in a verified finding of abuse, neglect, or threatened harm) were included in the analysis. The first and second episodes of maltreatment were selected based on the dates the reports of child maltreatment were received.

Recurrence of verified child maltreatment within 12 months. This indicator was based on entry cohorts, that is, all parents who were reported, subsequently investigated for alleged child maltreatment, and as a result of the child protection investigation, child maltreatment was found verified. For the FIT group, recurrence of maltreatment was defined as a subsequent verified child maltreatment report within 12 months after discharge from the FIT program. For

the comparison group, recurrence of maltreatment was defined as a second incident of verified maltreatment within 12 months of a child's first verified maltreatment incident. Only children with "verified" maltreatment (i.e., when the protective investigation resulted in a verified finding of abuse, neglect, or threatened harm) were included in the analysis. The first and second episodes of maltreatment were selected based on the dates the reports of child maltreatment were received.

Reentry into out-of-home care. This indicator was defined as reentry into out-of-home care within 12 months of their most recent discharge. This measure is based on the exit cohort. An exit cohort is defined as all children who exited out-of-home care during a certain time period as indicated by a *Discharge Date* in FSFN. Children were followed for 12 months from the date of discharge from out-of-home care to determine whether they were subsequently placed in out-of-home care as indicated by a new (second) *Removal Date* in FSFN. For the FIT group, only children who exited out-of-home care after their parents were discharged from FIT were selected.

Permanency. The number and proportion of all children exiting out-of-home care for permanency reasons within 12 months of the latest removal. This measure is based on an entry cohort, that is, all children who were placed in out-of-home care during a specific fiscal year as indicated by the "removal date" in FSFN. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved permanency. Permanency is defined as discharge from out-of-home care to a permanent home for the following reasons as indicated in FSFN: (a) reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker, (b) permanent guardianship (i.e., long-term custody or guardianship) with a relative or non-relative, and (c) adoption finalized, that is, when the Court enters the verbal order finalizing the adoption. For the FIT group, only children who entered out-of-home care after their parents were discharged from the program were selected.

Reunification with Original Caregivers. This measure is based on entry cohort. An entry cohort is defined as all children who were placed in out-of-home care during a given fiscal year and it is based on the date the child was removed from his/her home as indicated by a *Removal Date* in FSFN. Children were followed for 12 months from the date of removal from home to determine whether they were discharged from out-of-home care as indicated by *Discharge Date* in FSFN and achieved reunification, that is, the return of a child who has been removed to the removal parent or other primary caretaker. Reunification is identified based on one of the

reasons for discharge as indicated in FSFN. For the FIT group, only children who entered out-of-home care after their parents were discharged from the program were selected.

Part II: Study Findings

There were 3,025 parents (unduplicated counts) who were enrolled in and received the FIT program during fiscal years 2016-17, 2017-18, 2018-19, and 2019-20. If two parents of the same child were enrolled in the FIT program, one parent was randomly selected to avoid non-independence of observations. Of 3,025 parents enrolled in the FIT program, 445 successfully completed the program as indicated by the “reasons for discharge” data element in the FIT database. As a result of propensity score matching, 445 child welfare involved parents/guardians who did not receive FIT, but otherwise were similar to the FIT participants, were selected for the comparison group. Descriptive statistics were used to examine the obtained sample and compare parent or guardian/case characteristics for both groups. As shown in Table 8, these analyses revealed that the majority of the study sample were females (approximately 75 percent) and White (approximately 81 percent). The average age of the participants was approximately 33 years. Table 8 also presents the distribution of parent or guardian/case characteristics at the time they were either enrolled in the FIT program or were brought in contact with the child welfare system for the first time during a specific fiscal year. A substantial proportion (43 percent) of these children had parents/guardians who were investigated by the child protection system for neglect. Approximately, 29 percent of the parents/guardians in each group had a history of domestic violence. Smaller proportions of parents/guardians were investigated for sexual abuse (approximately 2.4 percent) or emotional abuse (less than 1 percent)

Table 8

Descriptive Statistics for FIT and Comparison Samples at Baseline After Propensity Score Matching

Baseline Characteristic*	FIT				Comparison Group			
	<i>n</i>	%	<i>M</i>	<i>SD</i>	<i>n</i>	%	<i>M</i>	<i>SD</i>
Demographics								
Age (in years)	445		33.1	6.78	45		32.4	7.94
Females	324	72.8			344	77.3		
White	357	80.2			362	81.3		
Black	82	18.4			68	15.3		
Hispanic	39	8.8			35	7.9		

Baseline Characteristic*	FIT				Comparison Group			
	<i>n</i>	%	<i>M</i>	<i>SD</i>	<i>n</i>	%	<i>M</i>	<i>SD</i>
Multiracial	2	0.4			2	0.4		
Type of child maltreatment								
Sexual abuse	5	1.1			16	3.6		
Physical abuse	30	6.7			35	7.9		
Neglect	206	46.3			177	39.8		
Emotional abuse	0	0			1	0.2		
Domestic violence	136	30.6			119	26.7		
Threatened harm	35	7.9			46	10.3		
Loss of a caregiver	9	2.0			12	2.7		
Substance use disorder								
Cocaine	93	20.9			91	21.8		
Stimulant	68	15.3			76	18.2		
Opioid	166	37.3			157	37.6		
Cannabis	145	32.6			47	11.3		
Alcohol	134	30.1			33	7.9		
Mental health disorders								
Mood disorder	138	31.0			110	26.4		
Anxiety disorder	65	14.6			70	16.8		
Personality disorder	1	0.2			4	1.0		
Other mental health disorder	10	2.2			7	1.7		

Note. *County was included as one of the baseline characteristics but was omitted from this table for purposes of legibility.

A substantial proportion of parents/guardians in both groups used opioids (37 percent), followed by cocaine (approximately 21 percent) and stimulants (approximately 17 percent). In addition, mood disorder was the most prevalent mental health diagnosis, with approximately 29 percent of the sample having this diagnosis. A smaller proportion of the participants were diagnosed with anxiety disorder (approximately 16 percent) and less than 1 percent were diagnosed with personality disorder.

Child maltreatment re-reports within six months. Approximately 13 percent of parents/guardians in the FIT intervention group and approximately 27 percent of parents/guardians in the comparison group were reported for alleged child maltreatment for the second time within six months of the initial child maltreatment report (see Table 9). Cox regression analysis was conducted to examine the effect of receiving FIT on the rates of child maltreatment re-reports within six months of completing the FIT program. The results indicated that there is a statistically significant difference (see Table A.22). Parents/guardians who received the FIT intervention were significantly less likely to have a subsequent child

maltreatment report compared to their counterparts in the comparison group. In particular, parents/guardians who did not receive FIT were over two times ($OR = 2.32, p < .01$) more likely to be reported a second time within six months of the initial child maltreatment report compared to those who completed the FIT program.

Child maltreatment re-reports within 12 months. Approximately, 20 percent of parents/guardians in the FIT intervention group and approximately 32 percent of parents/guardians in the comparison group were reported for alleged child maltreatment for the second time within the 12 months of the initial child maltreatment report (see Table 9). Cox regression analysis was conducted to examine the effect of receiving FIT on the rates of child maltreatment re-reports within 12 months. The results indicated that there is a statistically significant difference (see Table A.23). Parents/guardians who received the FIT intervention were significantly less likely to have a subsequent child maltreatment report within 12 months of the initial event compared to their counterparts in the comparison group. In other words, parents/guardians who did not receive FIT were 57 percent more likely ($OR = 1.51, p < .01$) to be reported a second time within 12 months after the initial child maltreatment report (see Table A.23).

Table 9

Rates of Child Maltreatment Re-reports within 6 and 12 months for FIT and Comparison Group Children (N = 890)

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Maltreatment re-reports within 6 months	56	12.6	119	26.7
Maltreatment re-reports within 12 months	87	19.6	139	31.2

Note. $n = 445$ (FIT); $n = 445$ (comparison group).

Recurrence of verified child maltreatment within six months. Rates of recurrence of verified child maltreatment within six months after the initial verified maltreatment were much smaller for the parents/guardians who received the FIT intervention. Approximately, 8 percent of parents/guardians in the intervention group and 16 percent of parents/guardians in the comparison group experienced recurrence of child maltreatment within six months of the initial incident (see Table 10). When the effect of receiving FIT on recurrence of maltreatment was examined, the results of the Cox regression analysis indicated a statistically significant difference between the groups (see Table A.24). Participants who did not receive FIT were over

two times more likely (OR = 2.23, $p < .01$) to experience recurrence of verified child maltreatment within six months after the initial event compared to their counterparts who received FIT.

Recurrence of verified child maltreatment within 12 months. The rate of recurrence of verified child maltreatment within 12 months after the initial verified maltreatment was bigger for the comparison group. Approximately, 14 percent of parents/guardians in the intervention group and 19 percent of parents/guardians in the comparison group experienced recurrence of child maltreatment within 12 months of the initial incident (see Table 10). When the effect of receiving FIT on recurrence of child maltreatment was examined, the results of the Cox regression analysis indicated no statistically significant difference between the groups (see Table A.25). Participants who received FIT were no more or less likely to experience recurrence of verified child maltreatment within 12 months after the initial event compared to their counterparts who did not receive FIT. However, the results of chi-square analysis [$\chi^2 (1, N = 890) = 4.26, p = .056$] indicated that the difference between the groups is approaching statistical significance.

Table 10

Rates of Verified Child Maltreatment Recurrence Within 6 and 12 months for FIT and Comparison Group Children

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Child maltreatment recurrence within 6 months	35	7.9	70	15.7
Child maltreatment recurrence within 12 months	61	13.7	83	18.7

Note. $n = 445$ (FIT); $n = 445$ (comparison group).

Reentry into out-of-home care. There were approximately 16 percent of parents/guardians in the FIT group whose children reentered out-of-home care within 12 months after discharge from child welfare out-of-home placement. The proportion of children who reentered out-of-home care in the comparison group was smaller – 9.2 percent (see Table 11). However, the results of the Cox regression analysis indicated that there is not a statistically significant difference between the groups (see Table A.26).

Table 11*Rates of Reentry into Out-of-Home Care for FIT and Comparison Group Children*

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Reentry into out-of-home care	20	15.9	15	9.2

Note. *n* = 445 (FIT); *n* = 445 (comparison group).

Permanency. Children of parents/guardians who received FIT achieved permanency faster and at a greater rate compared to their counterparts. As shown in Table 12, there were 40.9 percent of parents/guardians in the FIT group whose children exited out-of-home care for permanency reasons within 12 months after removal. The proportion of children who achieved permanency within 12 months after initial removal in the comparison group was smaller – 23.8 percent. The results of the Cox regression analysis indicated that receiving FIT had a significant positive effect on achieving timely permanency. Specifically, bivariate analysis indicated that children of parents/guardians who received FIT intervention were 79 percent more likely (OR = 1.79, $p < .05$) to achieve timely permanency compared to the children of parents/guardians who did not receive this intervention (see Table A.27).

Table 12*Proportion of Children Who Achieved Permanency for FIT and Comparison Group of Children*

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Exit from out-of-home care for permanency reasons	18	40.9	62	23.8

Note. *n* = 44 (FIT); *n* = 261 (comparison group).

Reunification with Original Caregiver. When the proportions of reunified children between the FIT group and the comparison group were compared, no significant difference was observed. There were 25 percent of children who achieved timely reunification whose parents/guardians received the FIT intervention. There was a smaller proportion (14.2 percent) of children who achieved timely reunification and whose parents/guardians did not receive such intervention (see Table 13). Results of Cox regression analyses demonstrated that there was no significant effect of FIT on reunification within 12 months of the latest removal (see Table A.28).

Table 13

Proportion of Children Who Were Reunified with Their Original Caregivers for FIT and Comparison Group of Children

Measure	FIT		Comparison Group	
	<i>n</i>	%	<i>n</i>	%
Exit from out-of-home care for reunification reason	11	25.0	37	14.2

Note. *n* = 44 (FIT); *n* = 261 (comparison group).

Part II: Discussion of the Study Analysis

Similar to the findings of the study that utilized the “intent to treat” design, the results of additional analyses as part II of the study have shown support for the FIT intervention. Findings based on the four cohorts (SFY 2016-17, 2017-18, 2018-19, and 2019-20) that successfully completed the FIT program indicated that compared to a group of similar parents/ guardians receiving child welfare services, parents/guardians who received all necessary services were less likely to have new allegations of maltreatment within six months of the initial incident and were less likely to be reported for child maltreatment for the second time within 12 months after the discharge from the program.

Findings also support the FIT intervention when recurrence of maltreatment was examined. If parents/guardians successfully completed the program, they were over two times less likely to experience recurrence of verified child maltreatment within six months after FIT program completion, as compared to their counterparts who did not receive FIT. When recurrence of maltreatment within 12 months after FIT program completion was examined, the results of descriptive statistics indicated that the rate of maltreatment recurrence for the participants who successfully completed the FIT program was much smaller – approximately 14 percent – compared to the participants in the comparison group (almost 19 percent). However, no statistically significant difference was found. This can be explained by a relatively small sample size, and the type of analysis (Cox regression) that typically requires larger sample size to acquire power to detect an effect. When just the rates of recurrence of maltreatment within 12 months after FIT program completion were compared using chi-square analysis, the difference approached statistical significance.

Similar to the results obtained when the “intent to treat” design was utilized, no significant differences were found when the rates for reentry and rates of reunification were examined.

However, findings from the additional analyses based on the program completion cohort indicated that receiving FIT was associated with better permanency outcomes.

Limitations specific to this part of the study should be noted. First, only a small proportion (i.e., approximately 15 percent) of parents/guardians completed the FIT program. Although this is slightly higher than a typical completion rate reported by Oliveros and Kaufman (2011), the sample size was not large enough to detect a small effect size. Second, because FIT was implemented throughout Florida, and FIT provider agencies are independent of each other, they may use different definitions and interpretations of successful completion of treatment, therefore, we could miss participants who benefited from FIT but were not included in the analyses. Finally, due to the lack of information about specific circumstances leading to the program dropout, we could not examine factors that are mostly associated with program incompleteness. Future research should explore the influence of various risk factors and child welfare history on the progression of the treatment and program completion.

In sum, the current study demonstrated the important role FIT plays in assisting parents/guardians who face both challenges associated with child welfare involvement and substance use issues. Our findings also indicate a need for additional research on pathways to treatment completion and novel approaches to intervene when there is a risk for service disengagement or failure to complete the program.

References

- Anderson, A. J., & Bellfield, H. (1999). Functional Assessment of Mental Health and Addiction. *International Journal of Psychosocial Rehabilitation*, 4, 39-45.
- Bavolek, S. J., & Keene, R. G. (2005). AAPI online development handbook: The Adult-Adolescent Parenting Inventory (AAPI-2) assessing high-risk parenting attitudes and behaviors. Park City, UT: Family Development Resources. <https://edge.edx.org/assets/courseware/v1/cf4d30fc491e497727c24e144cf3c0c3/assetv1:GeorgetownX+CCHD+2016+type@asset+block/AAPI.pdf>
- Brook, J., McDonald, T. P., Gregoire, T., Press, A., & Hindman, B., (2010). Parental substance abuse and family reunification. *Journal of Social Work Practice in the Addictions*, 10, 393–412.
- Courtney, M. E., & Hook, J. L. (2012). Evaluation of the impact of enhanced parental legal representation on the timing of permanency outcomes for children in foster care. *Children and Youth Services Review* 34, 1337-43.
- Cox, D. R. (1972). Regression models and life tables. *Journal of the Royal Statistical Society*, 34, 187-220.
- Dehejia, R. H., & Wahba, S. (2002). Propensity score-matching methods for nonexperimental causal studies. *Review of Economics and Statistics*, 84(1),151-161.
- Family First Act. (2022). Family First Prevention Services Act. <https://familyfirstact.org/about-law>
- Florida Department of Children and Families (2020). *Family intensive treatment (FIT), integrating behavioral health and child welfare practice model*.
- Ghertner, R., Waters, A., Radel, L., & Crouse, G. (2018). The role of substance use in child welfare caseloads. *Children and Youth Services Review*, 90, 83–93.
- Grella, C. E., Needell, B., Shi, Y., & Hser, Y. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, 36, 278–293.
- McCaffrey, D. F., Ridgeway, G., & Morral, A. R. (2004). Propensity score estimation with boosted regression for evaluating causal effects in observational studies. *Psychological Methods*, 9(4), 403-425. <http://dx.doi.org/10.1037/1082-989X.9.4.403>
- Oliveros, A., & Kaufman, J. (2012). Addressing Substance Abuse Treatment Needs of Parents Involved with the Child Welfare System. *Child Welfare*, 90(1), 25-41.

- Robst, J., Armstrong, M., Yampolskaya, S., Sowell, C., & Cruz, A. (2019). *The family intensive treatment (FIT) evaluation phase two quantitative report*. Tampa, FL: University of South Florida, College of Behavioral & Community Sciences.
- Rosenbaum, P. R., & Rubin, D. B. (1984). Reducing bias in observational studies using subclassification on the propensity score. *Journal of the American Statistical Association*, 79(387), 516-524. <http://dx.doi.org/10.2307/2288398>
- Rubin, D. B., & Thomas, N. (1996). Matching using estimated propensity scores: Relating theory to practice. *Biometrics*, 52(1), 249-264. <http://dx.doi.org/10.1017/CBO9780511810725.024>
- Rubin, D. B. (1997). Estimating causal effects from large data sets using propensity scores. *Annals of Internal Medicine*, 127(8 Part 2), 757-763. <http://dx.doi.org/10.7326/0003-4819-127-8 Part 2-199710151-00064>
- Scott, R. L. & Presmanes, W. S. (2001). Reliability and Validity of the Daily Living Activities Scale: A Functional Assessment Measure for Severe Mental Disorders. *Research on Social Work Practice*, 11, 373-389.
- Seay, K. D., & Kohl, P. L. (2015). The comorbid and individual impacts of maternal depression and substance dependence on parenting and child behavior problems. *Journal of Family Violence*, 30(7), 899–910.
- Smith, V. C., Wilson, C. R., Ryan, S. A., Gonzalez, P. K., Patrick, S. W., Quigley, J., Siqueira, L., Walker, L. R. (2016). Families affected by parental substance use. *Pediatrics*, 138(2), e1-e13.
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021a). *The AFCARS report: Preliminary FY 2020 estimates as of October 2021- No.28*. Washington, D.C.: USDHHS. <https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport28.pdf>
- U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021b). *Child Maltreatment 2019*. <https://www.acf.hhs.gov/cb/report/child-maltreatment-2019>
- U.S. Department of Health and Human Services. Children's Bureau. An Office of the Administration for Children & Families. (2022). CFSR Round 3 Statewide Data Indicators Workbook, May 2022. <https://www.cfsrportal.acf.hhs.gov/resources/round-3-resources/cfsr-round-3-statewide-data-indicators>

Appendix: Cox Regression Results

Table A.1

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Child Maltreatment Re-Reports Within 6 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.38	42.73*	.69	.61	.77

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.2

Cox Regression Results. Factors Associated with Child Maltreatment Re-Reports Within 6 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.38	41.98*	.69	.61	.77
Caretaker age	-.00	.98	1.00	.99	1.00
Caretaker gender	-.05	.43	.96	.84	1.09
Caretaker White	.42	3.10	1.52	.95	2.42
Caretaker Black	.37	2.31	1.45	.90	2.35
Caretaker Hispanic	-.14	1.94	.87	.71	1.06

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.3

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Child Maltreatment Re-Reports Within 12 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.28	36.38*	.75	.69	.83

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.4*Cox Regression Results. Factors Associated with Maltreatment Re-Reports Within 12 Months*

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				<i>LL</i>	<i>UL</i>
FIT	-.28	35.59*	.76	.69	.83
Caretaker age	-.00	1.77	1.00	.99	1.00
Caretaker gender	-.07	1.46	.94	.84	1.04
Caretaker White	.41	4.49*	1.50	1.03	2.18
Caretaker Black	.37	3.55	1.45	.99	2.13
Caretaker Hispanic	-.09	1.22	.91	.78	1.07

Note. *LL* = lower limit; *UL* = upper limit.**p* < .05.**Table A.5***Cox Regression Results. Effect of Family Intensive Treatment (FIT) on Recurrence of Verified Child Maltreatment Within 6 Months*

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				<i>LL</i>	<i>UL</i>
FIT	.06	.23	1.07	.83	1.36

Note. *LL* = lower limit; *UL* = upper limit.**p* < .05.**Table A.6***Cox Regression Results. Factors Associated with Recurrence of Verified Child Maltreatment Within 6 Months*

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				<i>LL</i>	<i>UL</i>
FIT	.06	.26	1.067	.83	1.37
Caretaker age	-.00	.01	.999	.98	1.02
Caretaker gender	.00	.00	1.003	.75	1.34
Caretaker White	1.04	2.13	2.820	.70	11.35
Caretaker Black	.65	.79	1.915	.46	7.99
Caretaker Hispanic	-.07	.11	.929	.60	1.43

Note. *LL* = lower limit; *UL* = upper limit.**p* < .05.

Table A.7

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Recurrence of Verified Child Maltreatment Within 12 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.08	.60	1.08	.89	1.32

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.8

Cox Regression Results. Factors Associated with Recurrence of Verified Child Maltreatment Within 12 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.08	.62	1.08	.89	1.32
Caretaker age	.00	.27	1.00	.99	1.02
Caretaker gender	-.10	.72	.90	.71	1.14
Caretaker White	.82	2.63	2.26	.84	6.06
Caretaker Black	.43	.70	1.54	.56	4.27
Caretaker Hispanic	.15	.90	1.16	.85	1.59

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.9

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Reentry into Out-of-Home Care

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.19	3.12	1.20	.98	1.48

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.10*Cox Regression Results. Factors Associated with Reentry into Out-of-Home Care*

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.21	3.77	1.23	1.00	1.52
Caretaker age	-.03	11.25*	.97	.96	.99
Caretaker gender	-.18	2.08	.83	.65	1.07
Caretaker White	.54	1.41	1.71	.71	4.16
Caretaker Black	.15	.10	1.16	.46	2.91
Caretaker Hispanic	-.05	.09	.95	.67	1.35

Note. LL = lower limit; UL = upper limit.* $p < .05$.**Table A.11***Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Permanency Outcomes Within 12 months of the Latest Removal*

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.14	4.37*	1.15	1.01	1.31

Note. LL = lower limit; UL = upper limit.* $p < .05$.**Table A.12***Cox Regression Results. The Effect of Family Intensive Treatment (FIT) and Demographic Characteristics on Reunification with Original Caregiver Within 12 months of the Latest Removal*

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.14	4.39*	1.15	1.01	1.31
Caretaker age	.01	3.22	1.01	1.00	1.02
Caretaker gender	-.04	.20	.97	.83	1.13
Caretaker White	.10	.17	1.10	.69	1.76
Caretaker Black	-.05	.05	.95	.58	1.55
Caretaker Hispanic	-.17	1.74	.85	.66	1.08

Note. LL = lower limit; UL = upper limit.* $p < .05$.

Table A.13

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Reunification with Original Caregiver Within 12 months of the Latest Removal

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.10	.02	.99	.85	1.16

Note. LL = lower limit; UL = upper limit.

Table A.14

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) and Demographic Characteristics on Reunification with Original Caregiver Within 12 months of the Latest Removal

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.00	.00	1.00	.85	1.17
Caretaker age	.01	2.00	1.01	1.00	1.02
Caretaker gender	.02	.03	1.02	.84	1.23
Caretaker White	-.23	.79	.80	.49	1.31
Caretaker Black	-.44	2.66	.64	.38	1.09
Caretaker Hispanic	-.35	4.32*	.71	.51	.98

Note. LL = lower limit; UL = upper limit.

Table A.15

Summary of Multiple Regression Analysis for the Emotional Subscale Score of the Caregiver Protective Capacities Measure Among Parents Who Received Family Intensive Treatment (FIT)

Risk Factor	<i>B</i>	<i>SE</i>	β	<i>t</i>	95% CI	
					LL	UL
Caretaker age	-.01	.01	-.01	-.47	-.03	.02
Caretaker gender	-.04	.18	-.00	-.23	-.40	.32
Caretaker White	-.55	.55	-.05	-1.00	-1.62	.52
Caretaker Black	-.59	.56	-.05	-1.05	-1.69	.52
Caretaker Hispanic	.15	.28	.01	.55	-.39	.70
Emotional subscale	.86	.02	.84	54.65*	.83	.89
FIT	.32	.14	.04	2.37*	.06	.60

Note. LL = lower limit; UL = upper limit. Dependent Variable: POST_EM

* $p < .05$

Table A.16

Summary of Multiple Regression Analysis for the Behavioral Subscale Score of the Caregiver Protective Capacities Measure Among Parents Who Received Family Intensive Treatment (FIT)

Risk Factor	<i>B</i>	<i>SE</i>	β	<i>t</i>	95% CI	
					<i>LL</i>	<i>UL</i>
Caretaker age	-.00	.01	-.01	-.30	-.02	.01
Caretaker gender	-.13	.17	-.01	-.77	-.46	.20
Caretaker White	-.15	.50	-.02	-.29	-1.13	.84
Caretaker Black	-.05	.52	-.01	-.09	-1.06	.97
Caretaker Hispanic	.06	.26	.00	.25	-.44	.57
FIT	.24	.13	.03	1.92	-.01	.49
Behavioral subscale	.83	.02	.82	49.49*	.80	.87

Note. *LL* = lower limit; *UL* = upper limit. Dependent Variable: POST_BEH

**p* < .05.

Table A.17

Summary of Multiple Regression Analysis for the Cognitive Subscale Score of the Caregiver Protective Capacities Measure Among Parents Who Received Family Intensive Treatment (FIT)

Risk Factor	<i>B</i>	<i>SE</i>	β	<i>t</i>	95% CI	
					<i>LL</i>	<i>UL</i>
Caretaker age	-.01	.01	-.01	-.63	-.03	.01
Caretaker gender	-.01	.17	-.00	-.06	-.34	.32
Caretaker White	-.02	.49	-.00	-.04	-.99	.95
Caretaker Black	-.00	.51	.00	-.01	-1.00	.1.00
Caretaker Hispanic	.14	.25	.01	.56	-.35	.64
FIT	.15	.13	.02	1.16	-.10	.39
Cognitive subscale	.84	.02	.83	51.58*	.81	.87

Note. *LL* = lower limit; *UL* = upper limit. Dependent Variable: POST_COGN

**p* < .05.

Table A.18

Summary of Multiple Regression Analysis for the Total Score on Caregiver Protective Capacities Measure Among Parents Who Received Family Intensive Treatment (FIT)

Risk Factor	<i>B</i>	<i>SE</i>	β	<i>t</i>	95% CI	
					<i>LL</i>	<i>UL</i>
Caretaker age	-.00	.05	.00	-.01	-.10	.10
Caretaker gender	-.41	.81	-.01	-.51	-2.00	1.18
Caretaker White	-.35	2.40	-.01	-.15	-5.07	4.37
Caretaker Black	-1.30	2.48	-.03	-.53	-6.18	3.57
Caretaker Hispanic	.30	1.23	.01	.25	-2.11	2.71
FIT	1.44	.61	.05	2.35*	.24	2.63
Caregiver protective capacity total score	20.50	.61	.69	33.86*	19.31	21.69

Note. *LL* = lower limit; *UL* = upper limit. Dependent variable: POST_PR_CAP

**p* < .05.

Table A.19

Results of Paired T-Test. Mean Scores of the Functional Assessment of Mental Health and Addiction (FAMHA) at Pre- and Post-FIT Intervention

Measure	<i>Pre-Test</i>		<i>Post-Test</i>		<i>df</i>	<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
FAMHA	84.23	25.05	94.96	31.19	475	-10.11	.000

Table A.20

Results of Paired T-Test. Mean Scores of the Adult-Adolescent Parenting Inventory (AAPI) at Pre- and Post-FIT Intervention

Measure	<i>Pre-Test</i>		<i>Post-Test</i>		<i>df</i>	<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
AAPI	29.50	15.92	33.41	19.34	848	-8.95	.000

Table A.21

Results of Paired T-Test. Mean Scores of the Daily Living Activities (DLA) at Pre- and Post-FIT Intervention

Measure	Pre-Test		Post-Test		df	t	p
	M	SD	M	SD			
DLA-20	71.77	33.55	89.31	34.32	816	-15.57	.000

Table A. 22

Cox Regression Results. Effect of Family Intensive Treatment (FIT) on Recurrence of Verified Child Maltreatment Within 6 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.85	27.20*	.43	.31	.59

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A. 23

Cox Regression Results. Effect of Family Intensive Treatment (FIT) on Recurrence of Verified Child Maltreatment Within 12 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.46	10.75*	.64	.48	.83

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.24

Cox Regression Results. Factors Associated with Recurrence of Verified Child Maltreatment Within 6 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.73	12.48*	.48	.32	.72

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.25

Cox Regression Results. Factors Associated with Recurrence of Verified Child Maltreatment Within 12 Months

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	-.21	1.46	.81	.58	1.14

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.26

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Reentry into Out-of-Home Care

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.53	2.39	1.70	.87	3.31

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.27

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Permanency Outcomes Within 12 months of the Latest Removal

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.58	4.74*	1.79	1.06	3.03

Note. LL = lower limit; UL = upper limit.

* $p < .05$.

Table A.28

Cox Regression Results. The Effect of Family Intensive Treatment (FIT) on Reunification with Original Caregiver Within 12 months of the Latest Removal

Risk Factor	Cox Regression Model Parameters				
	β	Wald χ^2 (1)	OR	95% CI	
				LL	UL
FIT	.60	3.05	1.82	.93	3.57

Note. LL = lower limit; UL = upper limit.

* $p < .05$.