The Relationship Between Substance Use and Foster Care: A Mixed Methods Study

ASPE Generic Information Collection Request
OMB No. 0990-0421

Supporting Statement – Section A

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Section A – Justification

1. Circumstances Making the Collection of Information Necessary

Background

After years of decline, the national foster care caseload has been rising over the past four years. Between 2011 and 2015, the number of children in care rose from 397,000 to 428,000, an 8 percent increase[1]. This increase is troubling for a number of reasons. These include that foster care typically results from abuse or neglect and extreme family dysfunction which is detrimental to children. In addition, research has shown that children in foster care are at higher risk of poor health outcomes and risky behaviors than are other children, which can lead to them having greater health care needs (Bruskas, 2010, Tyler & Melander, 2010). In addition, children in foster care are more likely to receive psychotropic medication and experience substance use disorder (Leslie et. al, 2010; Vaughn, et al., 2007). The rising need for foster care also strains community resources both in terms of the costs of providing care and because it may be difficult to recruit high quality foster homes for an increasing number of children. Finally, that numbers are rising after long term efforts to reduce the caseload means that gains are being undone, at least in some counties.

Parental substance use—particularly the mis-use of prescription opioids and opioid use disorder (with respect to illicit opioids such as heroin), is often cited in the news media as the primary cause for this recent increase in foster care caseloads (e.g., Wiletz, 2016) but there has been little empirical evidence in the research literature to support this claim. Preliminary quantitative analysis conducted by staff at the Assistant Secretary for Planning and Evaluation (ASPE) has identified a positive association between various indicators of substance use, including opioid use, and foster care caseloads at the national level over the past five years.[2] Initial work also suggests that the availability of addiction treatment facilities may influence the number of children in foster care in certain geographic locations. However, relationships among these factors are variable at the county level and there are counties in which high opioid levels are not associated with high or increasing foster care caseloads, despite the national level association.

Little is known about how child welfare agencies respond to changes in the rates of substance misuse and differences in drugs of abuse in their communities, though some specific pilot programs have been documented (Oliveros, 2011; National Center on Substance Abuse and Child Welfare, 2014). States report that 32 percent of children entering foster care in 2015 were removed from their home at least in

[1] Administration for Children and Families (2016) *Trends in Foster Care and Adoption*. Available at: https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption-fy15.

[2] These analyses have not yet been published but are based on secondary analysis of county-level data from several sources including: DEA data regarding opioid prescriptions, CDC data regarding overdose deaths, and CMS data regarding Medicare prescriptions for opioids.

part because of parental drug abuse[3]. Preliminary discussions with child welfare agencies at the state level conducted by the Administration for Children and Families (ACF) in 2016 also revealed that many agencies are faced with higher caseloads due to parental substance use. In addition, communities also often lack resources to support children and families in order for children to remain at home safely. This includes resources to support families while parents receive treatment. The potential collaboration between substance use treatment programs and child welfare is not well-documented. This is an area with substantial policy implications.

In 2017, ASPE funded a new project, "The Relationship between Foster Care and Substance Use: A Mixed Methods Study," to analyze the intersection of foster care and substance use. ASPE analyzed quantitative data at the county level to examine the relationship between substance use and the child welfare foster care caseload. The quantitative analysis involves statistical modeling of longitudinal data (drug use data as noted in footnote 2 as well as ACF data regarding foster care). The quantitative analysis has been conducted with input and review by an advisory group of experts across the U.S. Department of Health and Human Services (HHS).

This data collection is being conducted using the Generic Information Collection mechanism through ASPE – OMB No. 0990-0421. Qualitative data will be collected from state and local child welfare administrators, child welfare practitioners, state and local substance abuse administrators, staff from substance abuse treatment centers, family court staff, law enforcement officials, and other administrators and practitioners. This information collection request seeks OMB's approval to conduct the qualitative interviews and small discussion groups.

This supporting statement describes the quantitative analysis which is the subject of this request. Mathematica Policy Research has been contracted by ASPE to collect and analyze the qualitative data. The qualitative data will provide rich contextual information that will aid our understanding of the relationship between substance use and child welfare and why the relationship may differ by geography. The qualitative aspects of the study will be conducted in collaboration with ACF's Administration for Children, Youth and Families (ACYF), and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). The contractor will conduct semi-structured interviews and small discussion groups in 10 locations facing different patterns of child welfare cases and substance use levels. Participants will include child welfare administrators and practitioners, and state substance abuse agency directors and substance abuse treatment center directors and providers. Interview and small discussion group protocols have been developed in conjunction with ACF and SAMHSA stakeholders, and the HHS advisory group, including experts in ASPE, ACYF, SAMHSA, and NIDA and can be reviewed in Attachments C through G.

[3] Unpublished ASPE tabulations of Adoption and Foster Care Analysis Reporting System (AFCARS) data ffor 2015.

This mixed methods approach is intended to help to untangle the complexities in the heterogeneous relationship between substance abuse and child welfare. Results are expected to inform state administrators' practices, and inform both ACF and SAMHSA on future research and the provision of technical assistance that may reduce the impact of substance use on families and increase the likelihood that children can remain with their parents.

2. Purpose and Use of the Information Collection

The purpose of this data collection is to:

- Understand the relationship between foster care caseloads and substance use, at 10 sites;
- Determine how changing patterns of substance use impacts foster care caseloads in a county; and
- Gain an understanding of the community-level factors that may contribute to the county level variation in the relationship between substance use and foster care caseloads.

Qualitative data collection is needed for this study to augment information obtained through the quantitative data analysis of county-level foster care rates prescription opioid sales, and other measures related to substance use. Without obtaining qualitative data, we will be more limited in our interpretation of the intersection between foster care and substance use for the selected counties. To improve our analysis, we need to speak with individuals working in both systems so that we can better understand the relationship between foster care and substance use, the contextual factors involved, and any geographic differences.

The data will be used to inform practices in child welfare, and inform both ACF and SAMHSA on future research that may reduce the impact of substance use on families and increase the likelihood that children can remain with their parents.

3. Use of Improved Information Technology and Burden Reduction

Five of the site visits will occur through webinars and/or phone interviews to accommodate locations where in-person interviews would be burdensome, due to circumstances such as lack of centralized staff, cost of travel, or scheduling difficulties.

4. Efforts to Identify Duplication and Use of Similar Information

It is our understanding that no other prior or current research efforts have substantial overlap with our proposed investigation. A review of relevant literature revealed that there is little empirical evidence of parental substance use as the primary cause for the recent increase in foster care caseloads nationally. We are not aware of any previous or ongoing qualitative research investigating the intersection of child welfare and substance use, specifically at the county level through interviews and small group discussions.

The information collected through this study will build on previous and ongoing work related to the intersection of foster care and substance use. For instance, the U.S. Government Accountability Office (GAO) has recently fielded a survey to child welfare administrators on state policies and activities that relate to substance-affected infants. While it will have some overlap with our research, the GAO survey focuses heavily on state-level policies exclusively for developing safe care plans for substance-exposed infants.

5. **Impact on Small Businesses or Other Small Entities**
   No small businesses will be involved in this data collection.

6. **Consequences of Collecting the Information Less Frequently**
   This request is for a one time data collection. There are no legal obstacles to reduce the burden.

7. **Special Circumstances Relating to the Guidelines of 5 CFR 1320.5**
   There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

8. **Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency**
   This data collection is being conducted using the Generic Information Collection mechanism through ASPE – OMB No. 0990-0421, therefore no Federal Register notice is required.

9. **Explanation of Any Payment or Gift to Respondents**
   ASPE will not provide payments or gifts to respondents.

10. **Assurance of Confidentiality Provided to Respondents**
    The Privacy Act does not apply to this data collection. State and local administrators and practitioners who answer questions will be answering in their official roles and will not be asked about, nor will they provide, sensitive individually identifiable information.

11. **Justification for Sensitive Questions**
    No information will be collected that is of personal or sensitive nature.

12. **Estimates of Annualized Burden Hours and Costs**
    The estimate for burden hours is 120 minutes per response from child welfare administrators and practitioners, 90 minutes per response from substance use administrators and practitioners, and 60 minutes per response from other collaborating service program staff identified as key partners by the child welfare and substance misuse treatment agencies. We plan to interview at least 8 participants and up to 19 from each site, totaling a maximum of 190 participants across all 10 sites. We anticipate most small group interviews will be used to solicit information from caseworkers or practitioners and will occur in higher population

areas where there are more service providers. We also expect to hold one interview each with representatives from local law enforcement and local judicial or other legal professionals.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) 2015 National Occupational Employment and Wage Estimates (https://www.bls.gov/oes/current/oes_nat.htm). Table A-1 shows estimated burden and cost information.

Table A-1: Estimated Annualized Burden Hours and Costs to Respondents—Foster Care and Substance Use Survey

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in minutes)	Total Burden Hours	Hourly Wage Rate[4]	Total Respondent Costs
Child Welfare Administrators Attachment C	30	1	120	60	$33.38	$2,003
Child Welfare Practitioners Attachment D	20	1	120	40	$22.41	$896
Substance Use Treatment Program Practitioners Attachment E	20	1	90	30	$20.64	$619
Substance Use Administrators Attachment F	30	1	90	45	$50.99	$2,295
Administrators in Related Fields Attachment G	30	1	60	30	$50.99	$1,530
Practitioners in	20	1	60	20	$19.30	$386

[4] Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) 2015 National Occupational Employment and Wage Estimates (https://www.bls.gov/oes/current/oes_nat.htm).

Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in minutes)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Related Fields Attachment G						
Law Enforcement Officials Attachment G	20	1	60	20	$37.96	$759
Judicial or Legal Representatives Attachment G	20	1	60	20	$63.64	$1,273
TOTALS	190			265		$9,761

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There will be no direct costs to the respondents other than their time to participate in each data collection.

14. Annualized Cost to the Government

The cost of the government task order attributable to the work is $1,340.

Table A-2: Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Site	Average Hourly Rate	Average Cost
Social Science Analyst, GS 14	2	67.00	$134
Estimated Total Cost of Information Collection (x10 sites)			**$1,340**

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation and Publication and Project Time Schedule

After the site interviews and small discussion groups, the contractor will prepare site-specific summaries using standardized templates to document key findings

across participants, which will be coded and analyzed with NVivo to help identify key themes.

The contractor will prepare a report for ASPE to summarize study findings. ASPE plans to publically disseminate the overarching findings from this study. The dissemination plan has not yet been determined, but could include conference presentations, briefs, webinars, and other written products.

Project Time Schedule

- February–March 2017: Develop discussion guides and recruitment plan
- May–June 2017: Outreach and scheduling of site visits/interviews
- May–July 2017: Conduct on-site and virtual interviews/small group interviews
- July–September 2017: Analyze interview/small discussion group findings and contractor will submit summary report to ASPE

17. Reason(s) Display of OMB Expiration Date is Inappropriate

We are requesting no exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

LIST OF ATTACHMENTS – Section A

Note: Attachments are included as separate files as instructed.

- Attachment A. Mixed Methods Study Site Selection Criteria
- Attachment B. Selected Sites and Their Characteristics
- Attachment C. Discussion Guide for Child Welfare Administrators
- Attachment D. Discussion Guide for Child Welfare Practitioners
- Attachment E. Discussion Guide for Substance Use Practitioners
- Attachment F. Discussion Guide for Substance Use Administrators
- Attachment G. Discussion Guide for Other Administrators and Practitioners