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# Evaluation of the Risk Reduction Training for Pregnant and Parenting Youth in Care

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# Abstract

This report presents findings from an evaluation of the Risk Reduction training developed by the Office of the Inspector General to reduce infant mortality among the children born to youth in care. The evaluation included six components: an analysis of TPSN program data; training observations; pre- and post-training questionnaires; youth interviews; trainer interviews; and an analysis of DCFS administrative data. Although we find evidence that pregnant and parenting youth in care are learning about practicing safe sleep, safely caring for young children, and promoting healthy child development, the training is not always being implemented as designed. Nor does it appear to be reducing child maltreatment rates. The report concludes with recommendations for how the training could be improved.

# Executive Summary

This report presents findings from an evaluation of the Risk Reduction training developed by the Office of the Inspector General for the Illinois Department of Children and Family Services to reduce infant mortality among children born to youth in care. The evaluation included five components: training observations; pre- and post-training questionnaires; youth interviews; trainer interviews; and an analysis of DCFS administrative data.

During the eight years between FY2012 and FY2019, 971 pregnant and parenting youth completed the training. The curriculum covers three main topics: (1) practicing safe sleep; (2) safely caring for young children; and (3) promoting healthy child development.

*TPSN Program Data*: Between July 1, 2011, when implementation of the Risk Reduction training began, and November 13, 2018, the last date for which we received data from TPSN, 1,339 youth in care were eligible to participate in the training. The training was completed by 57% (N = 756) of those youth. We do not know why 43 percent of the youth who were eligible for the training did not complete it, although females were about twice as likely to complete the training as males. Thirty six percent of the youth who completed the training did so before the birth of their first child who was born after July 1, 2011, 58 percent had completed the training within three months of their child's birth and 85 percent had completed the training by their child's first birthday.

*Training Observations*: We observed four training sessions between December 2018 and November 2019. The young people who attended the trainings were generally engaged in the activities, but often failed to adhere to the ground rules they had agreed to at the beginning of the session. Trainers did not always explain the purpose of the training, moved from one activity directly into another without providing any context, and did not synthesize the material covered at the end of each component. Additionally, the same activities were facilitated differently by different trainers and not all participants had an opportunity to participate in all of the activities.

*Pre- and post-training questionnaires*: Participants who attended one of the four trainings we observed were given the option of completing a brief questionnaire designed to assess whether participation in the training was associated with an increase in knowledge about the material covered. We found a statistically significant increase in the number of items participants answered correctly, and the biggest increase at the item level was in the percentage of participants who correctly indicated that having blankets in a crib with their infant is unsafe.

*Youth interviews*: We interviewed 14 young people who participated in the trainings we observed. Five of these young people were parenting and nine are female. Several of the young people we interviewed lacked a clear understanding of the training's purpose and they came to the training with different expectations as to what would be covered. Some were under the

impression that the training was voluntary whereas others were informed that they were required to attend. All but one young person reported learning valuable lessons about topics such as safe sleep and SIDS, shaken baby syndrome, choosing an appropriate caregiver and signs of abuse, and some reported being surprised by what they learned. Most of the young people who were already parents reported that the training led them to changing how they cared for the children. All but two of the youth reported being very satisfied with the training and all but one would recommend the training to a peer.

*Trainer interviews:* We interviewed four trainers and the training coordinator. Trainers noted that training capacity was limited because there are too few certified trainers who are willing to facilitate the trainings. This may be because some agencies that serve pregnant and parenting youth in care do not require their staff to become certified trainers and/or to facilitate the training because those activities are not included in their DCFS contract. Trainers agreed that engagement is key to a "good training" and described a number of strategies they use to engage youth. They also identified the number of participants and the dynamic that develops within the group as factors that affect engagement. A couple of trainers highlighted some of the differences between the materials that are used during the training for young women and the training for young men. Trainers also spoke about the challenges posed by participants' need for childcare.

*DCFS Administrative Data*: We used DCFS administrative data to examine allegations of child abuse and neglect involving parents who were eligible for the Risk Reduction training. Parents who completed the training were more likely to be the subject of at least one allegation (43% vs. 29%) and more likely to be the subject of at least one indicated allegation (26% vs. 18%) prior to their child's first birthday than parents who did not complete the training. Additionally, regardless of whether parents had completed the training or not, nearly all the allegations—and nearly all the indicated allegations---involved neglect, primarily substantial risk of physical injury and inadequate supervision.

# Introduction

During FY 2011, the Office of the Inspector General conducted a Ten-Year Review (2000-2010) of the deaths of 27 infants whose parents were youth in DCFS care.[1] The review found that 11 infants died as the result of sleep related events: 7 infants were unintentionally suffocated when someone rolled over onto the baby; 3 infants suffocated after becoming trapped in a position from which they could not extricate themselves, and 1 infant died from hyperthermia after being left bundled in a crib next to a heated radiator. Ten infants were the victims of homicide. In three of those cases, the father was unable to cope with the infant's crying.

Based on the findings of its review, the Office of the Inspector General developed a risk reduction training as part of its efforts to reduce infant mortality among the children born to youth in care. The aims of this interactive and discussion-driven training are to educate young parents on the importance of always placing infants to sleep in a safe environment; non-violent and soothing responses to infant crying; choosing appropriate caregivers for their children; supportive responses to challenging developmental behaviors; promoting infant brain development through talking, touching, reading, and playing; the mechanics of abusive head trauma; and, warning signs of non-accidental bruising. The training, which was first piloted in March 2011, is now mandatory for all pregnant or parenting youth in care. Partners of youth in care who are pregnant or parenting are eligible to participate in the training, but their participation is not required.

The Teen Parent Services Network (TPSN), which oversees the provision of services and supports to pregnant and parenting youth in care throughout the state, has been responsible for coordinating the trainings statewide since 2013. Case managers are supposed to transport youth to the trainings and assist in finding childcare. Trainings generally take place in the late afternoon or early evening to accommodate school and work schedules.

According to the training manual, the training begins with the purpose of training, an icebreaker activity, and a discussion of the ground rules. The curriculum covers three main topics: (1) practicing safe sleep; (2) safely caring for young children; and (3) promoting healthy child development.

[1] Kane, D. (2012). *Report to the Governor and the General Assembly*. Springfield, IL: Office of the Inspector General Illinois Department of Children and Family Services.

**Table 1. List of Training Activities by Component**

| Components | Activity |
|---|---|
| Introduction | Motivation for the Training |
| | Ice Breaker (Baby Proud) |
| | Discussion of Ground Rules |
| Safe Sleep | Pack N Play Setup |
| | Safe/Unsafe Sleep Pictures |
| | Safe Sleep Vignettes |
| | Baltimore Safe Sleep Video |
| Safely Caring for Young Children | Caregiver Qualities |
| | Mediation |
| | Taking Care of Baby Vignette |
| | Bruising Poster |
| | Mushroom Soup Demonstration |
| | Abusive Head Trauma – Infant Simulator |
| Promoting Healthy Child Development | Talk Touch Read Play with Play-doh |
| | Seven Deadly Sins |

DCFS contracted with Chapin Hall to evaluate the implementation of the training and the outcomes of training participants. The evaluation addresses the following research questions:

- Is the training being implemented as designed?
- What are young parents learning from the training?
- Is there any evidence that the training is reducing the risk for child maltreatment?
- How could the training be improved?

# Method

Our evaluation of the risk reduction training included multiple components: training observations; pre- and post-training questionnaires; trainer interviews; youth interviews; and an analysis of TPSN program data and DCFS administrative data. Each of the components is briefly described below.

## Analysis of TPSN program data

TPSN provided Chapin Hall with an Excel spreadsheet that included records for all youth in care who were the parent of at least one child born between July 1, 2011, when the risk reduction training began, and November 13, 2018. The records included DCFS identification numbers and birthdates for the parents and their children. For the parents who completed the risk reduction training, the spreadsheet also included the date they completed the training.

## Observation of trainings

We observed four training sessions between December 2018 and November 2019. Each training was held in the UCAN office in the south-side of Chicago. Although we had planned to observe one or more trainings downstate, that proved infeasible. In some cases, scheduled trainings were canceled; in other cases, we were not notified of training dates and times.

Young women and young men attend the training at the same time but in separate rooms. Because only one member of the evaluation team was available to observe each training, we moved between the two groups so that we could observe both. The drawback of this approach is that we were unable to observe any of the trainings in full. Moreover, because the group of young women was always far larger than the group of young men, we spent more time observing the young women's group.

## Administration of pre- and post-training questionnaires

We developed a 15-item true/false questionnaire that was designed to assess whether participation in the training was associated with a change in participants' knowledge about safe sleep as well as some of the other topics that the training covers. Our original plan called for the trainers to administer the questionnaires to participants before and after the completed the training. We created an on-line training for the trainers that explained not only how to administer the questionnaire and but also how to obtain informed assent/consent from participants. We also provided TPSN with the relevant materials including questionnaires and assent/consent forms. Unfortunately, few trainers completed the on-line training and none of

the questionnaires that were sent to the trainers by TPSN were administered. When it became apparent that our original plan was not working, we decided to limit our data collection to the four trainings we observed and that we would administer the questionnaires at those trainings.

Altogether, 47 pre-training questionnaires and 45 post-training questionnaires were completed.[2] One participant completed the post-training but not the pre-training questionnaire and three participants completed the pre-training but not the post-training questionnaire.

## Interviews with trainers

We interviewed four trainers and the training coordinator. The trainers facilitate trainings in Chicago and in the Central region.

## Interviews with youth who completed the training

At the end of each training we observed, participants were asked to fill out a consent to contact form if they were interested in being interviewed about their perceptions of the training. Forty-five participants indicated their willingness to be contacted for an interview. We attempted to contact 30 participants. Some did not respond to our repeated efforts; others could not be reached because the contact information they provided was outdated. Fourteen youth were interviewed.

## Analysis of DCFS administrative data

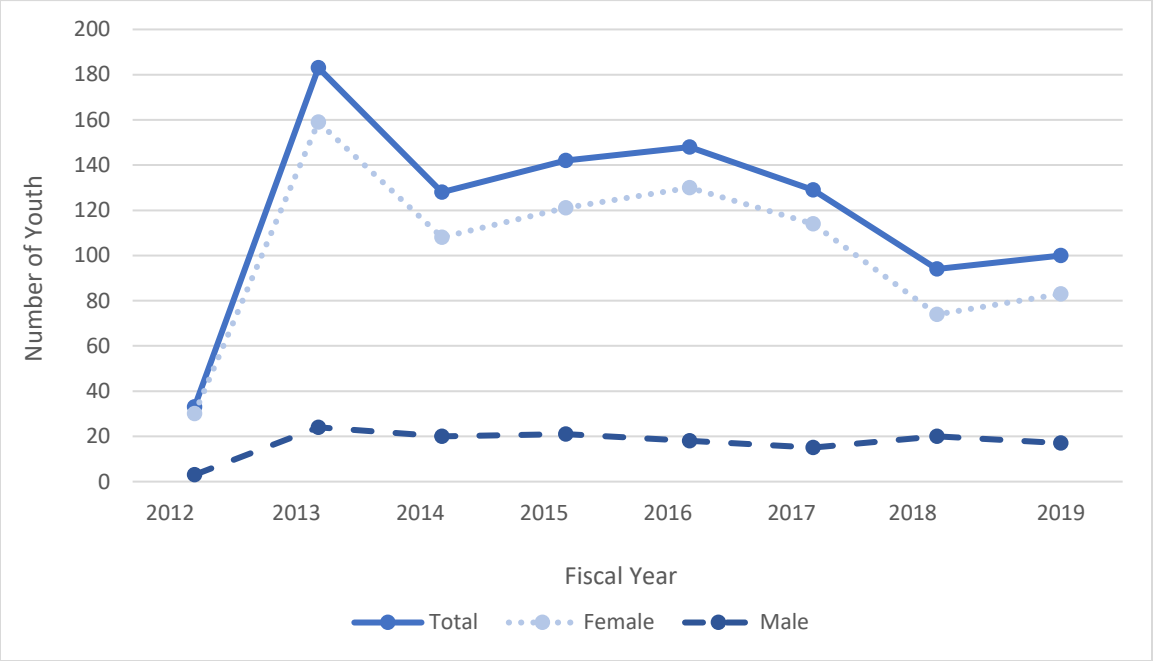
We used the parents' DCFS identification numbers in the TPSN Excel file to link the TPSN data to DCFS administrative data to examine allegations of child abuse and neglect involving parents who were eligible for the Risk Reduction training. Because a primary goal of the training is to reduce infant mortality, our analysis focused on investigations that took place prior to each child's first birthday.

[2] Based on the contact information young people who wanted to be interviewed shared, one young person attended two trainings. We do not know if this young person completed the questionnaires twice.

# Training Completion

Figure 1 shows the total number of pregnant and parenting youth in care who completed the Risk Reduction Training between July 1, 2011 and June 30, 2019 (i.e., fiscal years 2012 through 2019).[3] During that eight-year period, 971 pregnant and parenting youth---824 females and 147 males---completed the training. The number of youth completing the training peaked in 2013 when the training was completed by 183 youth. After declining for several years, the number of youth completing the training increased in 2019.

**Figure 1. Number of Youth Completing Risk Reduction Training by Year**




The Excel file we received from TPSN included data for 1,339 youth who gave birth to or fathered a child between July 1, 2011, when implementation of the Risk Reduction training began, and November 13, 2018, the last date for which received data from TPSN, and were in care on the date their child was born. Seventy-three percent of these youth are female and 27 percent are male. Fifty-seven percent of these youth had completed the training by November 13, 2018. Sixty-six percent of the females completed the training compared to 31 percent of the males. Fifty-four percent of the White youth completed the training compared to 57 percent of both the Black and Latinx youth.

[3] These figures do not include the partners of youth in care who are also eligible for the training if they are pregnant or parenting.

### Table 2. Risk Reduction Training Completion by Gender and Race

| | Completed Training | | Did Not Complete | |
|---|---|---|---|---|
| | # | % | # | % |
| Total | 756 | 56.5 | 583 | 43.5 |
| Gender | | | | |
| Female | 643 | 65.7 | 336 | 34.3 |
| Male | 113 | 31.4 | 247 | 68.6 |
| Race/ethnicity | | | | |
| Black | 531 | 57.2 | 397 | 42.8 |
| White | 136 | 54.0 | 116 | 46.0 |
| Hispanic | 69 | 57.0 | 52 | 43.0 |
| Multiracial | 1 | 50.0 | 1 | 50.0 |
| Missing | 19 | 52.8 | 17 | 47.2 |

Table 3 shows when pregnant and parenting youth completed the training relative to the timing of the birth of their first child who was born after July 1, 2011. Thirty six percent of the youth who completed the training did so before their child's birth. Fifty-eight percent had completed the training within three months of their child's birth and 85 percent had completed the training by their child's first birthday,

### Table 3. Timing of Risk Reduction Training Completion

| | # | % |
|---|---|---|
| Prior to birth of child | 272 | 36.0 |
| 0 to 3 | 166 | 22.0 |
| 4 to 6 | 93 | 12.3 |
| 7 to 12 | 110 | 14.6 |
| 13 to 18 | 54 | 7.1 |
| 19 to 24 | 39 | 5.2 |
| More than 24 | 22 | 2.9 |

Table 4 compares the living arrangements of youth who completed the training to the living arrangements of youth who did not complete the training one week prior to the birth of their first child who was born after July 1, 2011. The biggest differences between the two groups are that youth who completed the training were more likely to be placed in Transitional Living Programs (TLPs) and less likely to be placed in foster homes than youth who did not complete the training.

### Table 4. Placement Type by Training Completion

| | Completed Training (N = 756) | | Did Not Complete (N = 583) | |
|---|---|---|---|---|
| | # | % | # | % |
| Independent Living (ILO) | 176 | 23.3 | 147 | 25.2 |
| Transitional Living (TLP) | 158 | 20.9 | 79 | 13.6 |
| Foster Home | 146 | 19.3 | 135 | 23.2 |
| Relative Home/Fictive Kin | 102 | 13.5 | 90 | 15.4 |
| Unauthorized Placement | 49 | 6.5 | 29 | 5.0 |
| Residential Care | 33 | 4.4 | 16 | 2.7 |
| Whereabouts Unknown | 27 | 3.6 | 28 | 4.8 |
| Group Home | 17 | 2.2 | 9 | 1.5 |
| Shelter | 14 | 1.9 | 8 | 1.4 |
| Detention/Department of Corrections | 10 | 1.3 | 27 | 4.6 |
| Other | 24 | 3.2 | 15 | 2.6 |

Table 5 shows the training completion rate by placement type the week one week prior to the birth of their first child who was born after July 1, 2011. The completion rate was highest for youth placed in residential care, transitional living programs and group homes and lowest for youth in detention or Department of Corrections custody or whose whereabouts were unknown.

### Table 5. Training Completion Rate by Placement Type

| | N | # | % |
|---|---|---|---|
| Independent Living (ILO) | 323 | 176 | 54.5 |
| Transitional Living (TLP) | 237 | 158 | 66.7 |
| Foster Home | 281 | 146 | 52.0 |
| Relative Home/Fictive Kin | 192 | 102 | 53.1 |
| Unauthorized Placement | 78 | 49 | 62.8 |
| Residential Care | 49 | 33 | 67.3 |
| Whereabouts Unknown | 55 | 27 | 49.1 |
| Group Home | 26 | 17 | 65.4 |
| Shelter | 22 | 14 | 63.6 |
| Detention/Department of Corrections | 37 | 10 | 27.0 |
| Other | 39 | 24 | 63.2 |

# Findings: Observations of trainings

Below we present the findings from our observations of the four trainings we observed. We divide our discussion into four parts to correspond with the four components of the training: introduction, safe sleep, safely caring for young children, and promoting healthy child development. We conclude with a few general observations about the training.

## Training Part A: Introduction

This introductory component helps set the tenor of the training and includes three components: motivation for the training, an icebreaker exercise, and a discussion of the ground rules. At the last observed training, the female participants were provided with dry erase name tents. Having the name tents allowed the trainers and participants to refer to each other by name and helped foster a sense of community throughout the training. Only one of the four trainings we observed provided young people with information about the motivation for training and statistics related to child fatalities among the children of youth in care. Consequently, some young people may not have fully understood the training's purpose or importance.

All of the trainings included the Baby Proud icebreaker activity during which participants say their name; whether they or their partner is pregnant; their due date if they or their partner is pregnant; or the age of their child if they are a parent. Young people are also encouraged to share baby or sonogram pictures.

At each of the trainings, the trainers encouraged participants to suggest ground rules. Most of the agreed upon rules were similar across the trainings. Examples included: one person talks at a time and be respectful of others.

## Training Part B: Safe Sleep

The safe sleep component of the training includes four activities: the pack n play setup, the safe/unsafe sleep picture activity, the safe sleep vignettes, and the Baltimore safe sleep video.

There was a lot of variation across the four trainings in how the pack n play and the safe/unsafe sleep picture activities were executed. During three of the trainings, participants were divided into two groups, those who were familiar with putting together a pack n play and those who were not. The young people who were unfamiliar with a pack n play either worked together as a small group to figure out how to set it up and take it down, or individual participants volunteered to put the crib together and break it down in front of the small group. Those who were already familiar with the pack n play began the safe/unsafe picture activity, which involves making judgments about if sleeping environments depicted in photographs are safe or unsafe for a baby. After the two small group activities were completed, participants returned to their

seats to discuss the safe and unsafe pictures, which were posted on the wall, as a group. The discussion covered important points such as keeping toys, blankets, or bumpers out of cribs. However, participants in the pack n play group did not have an opportunity to observe the pictures closely or to decide whether the pictures depicted safe or unsafe sleeping arrangements. As a result, the discussion was probably less meaningful for them.

At the fourth training, all the participants engaged in the safe/unsafe picture activity and a spirited discussion followed. Then one participant demonstrated how to set up and break down the pack n play for the entire group. During the demonstration, many of the other participants were talking with one another rather than paying attention so participants who were unfamiliar with the pack n play may not have learned the correct way to use it.

At each of the four trainings, the trainers introduced the B'more for Healthy Babies Safe Sleep Campaign video by explaining that the video could be upsetting and letting participants know that they could step out of the room if needed.[4] The video shown to the young women is powerful and seemed to impact participants in a way that simply talking about SIDS might not. At some of the observed trainings, a trainer also shared a screenshot showing the internal anatomy of a baby whose airway was blocked because the baby was sleeping on its stomach.

At three of the trainings, participants read a vignette related to safe sleep from the OIG's *Safe Sleep for Our Baby* booklet after watching the video. At the fourth training, participants read the vignette at the beginning (rather than at the end) of the safe sleep component. Starting with the vignette provided context for the activities that followed.

### Training Part C: Safely Caring for Young Children

The third component of the training focus on caring for young children and promoting healthy child development. It consistently began with a discussion about the qualities participants would (and would not) like someone caring for their baby to have. This discussion would segue into reading either one or two vignettes from the OIG *Taking Care of Our Baby* booklet. Reading two vignettes seemed to allow for a richer discussion because the two stories could be compared. During one of the trainings, several of the young women reacted strongly to the vignette about a mother who left her baby with her boyfriend who physically abused the baby. The young women confidently asserted that they would never allow that to happen to their child. A supervisor, who was also observing the training, noted that she had worked with a smart, strong young mother in care who had said the same thing before her boyfriend beat her baby. The supervisor pointed out that you do not always realize how dangerous a situation is until something bad happens---even when others are warning you about the danger. The supervisor's comments seemed to strike a chord with the participants. Some nodded in

[4] According to the training manual, the male and female participants are shown different videos. The video shown to the young women is available at: https://www.youtube.com/watch?v=yBBiG6e4xRw.
Video shown to the young men is available at: https://www.youtube.com/watch?v=F194I4a5CLk.

recognition and there was a short discussion about the possibility of not believing it could happen to you.

The vignettes were typically followed by a discussion about accidental versus non-accidental bruising. Trainers referred participants to the "Bruising Poster" handout in their packets. Although the handout says that "babies who don't cruise rarely bruise," it was unclear if participants understood what this mean---namely, that infants who are not crawling or toddling are unlikely to be bruised accidentally. The trainers tended to emphasize the areas that mobile children might get bruises (e.g., knees, forearms, elbows, foreheads), but did not emphasize that that children who are not yet moving on their own should not have bruises. Also, the information on the handout is hard to discern. The photocopied sheet is not clear and would be easier to read if it were enlarged and on multiple sheets.

The next few activities all focus on head trauma and shaken baby syndrome. The first involves passing around a clear container of mushroom soup to demonstrate the consistency of a baby's brain. This activity seemed to resonate with participants, particularly when a trainer violently shook the container causing the soup to slosh up and down the side. Participants expressed their surprise at the fragility of a baby's brain. Next, participants watch a video about shaken baby syndrome. The video shows doctors demonstrating what happens to infant's brain when it is shaken using a shaken baby simulator.[5]

Following the video, the trainers pass around a baby simulator which lights up when the "baby's brain" is being damaged. At three of the trainings, participants took turns shaking the simulator and many seemed surprised that the simulator lit up after just a few seconds of mild shaking. However, at one of the trainings, two participants started playing with the simulator inappropriately so the trainer put it away before some of the participants had had a chance to interact with it.

## Part D: Promoting Healthy Child Development

We observed two activities related to promoting healthy child development. The first activity---Talk, Touch, Read, Play---is designed to stimulate ideas about the ways in which parents can interact with their children to promote brain development. Participants are given four different colors of play-doh which they are supposed to use to represent different types of activities they can engage in with their children (i.e., talking, touching, reading, and playing). At one of the four trainings we observed, this activity was executed well. The trainer asked participants to read aloud the descriptions of each activity-type. Then each participant was asked to provide an example of the activity and add a piece of play-doh to an object representing a baby's brain. At two of the trainings, the trainers did not explain the purpose of the activity and participants seemed confused because they were not provided with clear instructions. In fact, one of the trainers admitted to not knowing what participants were supposed to do with the play-doh. At a

[5] Available at: https://www.youtube.com/watch?v=8bx_X8Gm0Y4

third training, the activity was explained, but participants just played with the play-doh and talked to each other.

The second activity was a discussion about the challenges parents can expect during different developmental stages. The trainers used the *Seven Deadly Sins of Childhood* booklet to guide the discussions which typically covered topics such as potty training. At one of the trainings, the trainer explained that it is developmentally appropriate for toddlers to say "no" and asked participants to anticipate how they would respond if their child said "no" to them. Some of the young men participating in this training commented that it was good to know that saying "no" was normal and not a sign that their child was being defiant. At another training, the trainers talked about the need for parents to take some time to collect themselves if they are feeling overwhelmed or frustrated with their children.

## Other Observations

Several additional observations not tied to specific activities are also worth mentioning.

- Each of the observed trainings began about half an hour late and some participants still arrived after the training began. Two of the trainings also ended earlier than scheduled.
- Some participants brought their children to the training even though childcare is not provided. At one training, an otherwise well-behaved toddler ran around the room. At other trainings, infants or toddlers were cared for in another room by UCAN staff.
- The trainings lacked introductions to the activities, transitions between activities, or recaps at the end of the different sections of the training to synthesize the covered material.
- Participants often raised questions about topics like breastfeeding or newborn care that are probably more appropriate for a prenatal or postnatal parenting education class.
- Although the training manual includes instructions for leading a discussion about the Young Parent Mediation Program, the program was not mentioned during any of the trainings we observed.
- At three of the four trainings we observed, participants sometimes appeared restless and fatigued. Their attention seemed to wane over time, as did compliance with the ground rules they had established.

# Findings: Analysis of Pre- and Post-Training Questionnaire Data

Table 6 shows the percentage of training participants who responded correctly to the items on the questionnaires that were administered before and after each of the four trainings we observed. Only the responses of participants who answered the item on both the pre- and post-training questionnaire are reflected in these data.

For most of the items, the percentage of participants who responded correctly was higher after the training as compared to before the training. In most cases, however, the difference is relatively modest. This probably reflects the fact that many participants responded correctly to these items before completing the training. By far, the biggest change was the increase in the percentage of participants who correctly indicated that putting their baby in a crib with a blanket is unsafe. We also observed double digit increases in the percentage of participants who correctly indicated (1) that their baby should not sleep on a soft surface, (2) that African American babies are at higher risk for SIDS, and (3) that bruising on an infant is a sign of abuse. However, even after they had completed the training, a majority of participants did not respond correctly to the first two of these three items. In a few cases, the percentage of participants who responded correctly was lower after as compared to before the training but these differences were relatively small---2 to 3 percentage points at most.

**Table 6. Correct Responses to Items on the Pre- and Post-Training Questionnaires**

| | Pre-Training | | | Post-Training | | |
|---|---|---|---|---|---|---|
| | N | # | % | N | # | % |
| It is safe for my baby to sleep in bed with me. | 43 | 40 | 93.0 | 43 | 41 | 95.4 |
| It is safe to put a blanket in the crib with my baby.* | 42 | 26 | 61.9 | 42 | 41 | 97.6 |
| It is safe to put my baby down to sleep on his or her stomach. | 42 | 36 | 85.7 | 42 | 39 | 92.9 |
| It is safe to put a stuffed animal in the crib with my baby. | 40 | 33 | 82.5 | 40 | 37 | 92.5 |
| My baby should sleep on a soft surface.[6] | 40 | 7 | 17.5 | 40 | 13 | 32.5 |
| It is OK to shake my baby if my baby won't stop crying. | 42 | 42 | 100.0 | 42 | 42 | 100.0 |
| Talking and reading to my baby can help my baby's brain develop. | 41 | 41 | 100.0 | 41 | 40 | 97.6 |
| SIDS is the sudden and unexplained death of a baby under 1 year of age. | 36 | 31 | 86.1 | 36 | 32 | 88.9 |
| African American babies are at higher risk for SIDS than white babies. | 37 | 11 | 29.7 | 37 | 15 | 40.5 |
| Tummy Time can strengthen my baby's head, neck, and shoulder muscles. | 39 | 33 | 84.6 | 39 | 34 | 87.2 |
| Shaking my baby could cause abusive head trauma. | 38 | 38 | 100.0 | 38 | 36 | 94.7 |
| Mediation can help parents resolve conflicts and plan to share parenting responsibilities.[7] | 35 | 32 | 91.4 | 35 | 30 | 85.7 |
| Bruising on an infant under 1 year of age is a sign of abuse. | 37 | 31 | 83.8 | 37 | 35 | 94.6 |
| Physical abuse can affect a baby's brain. | 40 | 40 | 100.0 | 40 | 40 | 100.0 |
| It is normal for parents to become frustrated with their child's behavior. | 38 | 36 | 94.7 | 38 | 37 | 97.4 |

*Difference between pre- and post-training means statistically significant at $p < .05$.

In addition to looking at the responses to the individual items, we created two composite measures. The pre-training composite measure represents the number of items participants responded to correctly on the pre-training questionnaire; the post-training composite measure represents the number of items participants responded to correctly on the post-training questionnaire. We limited our analysis to participants who responded to all 15 items so scores on both composite measures can range from 0 to 15.

[6] In retrospect, the second item might have been less ambiguous if it had been worded "My baby should sleep on a firm surface." Had we worded the worded the item this way, an affirmative response would clearly have been correct.

[7] Mediation was not covered in the trainings we observed although it is included in the training manual.

Table 7 shows the frequency distribution for scores on both composite measures. Participants responded correctly to a mean of 12.2 items on the pre-training questionnaire and to a mean of 13.1 items on the post-training questionnaire. The results of a paired t-test indicated that this increase in the number of items participants responded to correctly is statistically significant.

**Table 7. Number of Correct Responses on the Pre- and Post-Training Questionnaire**

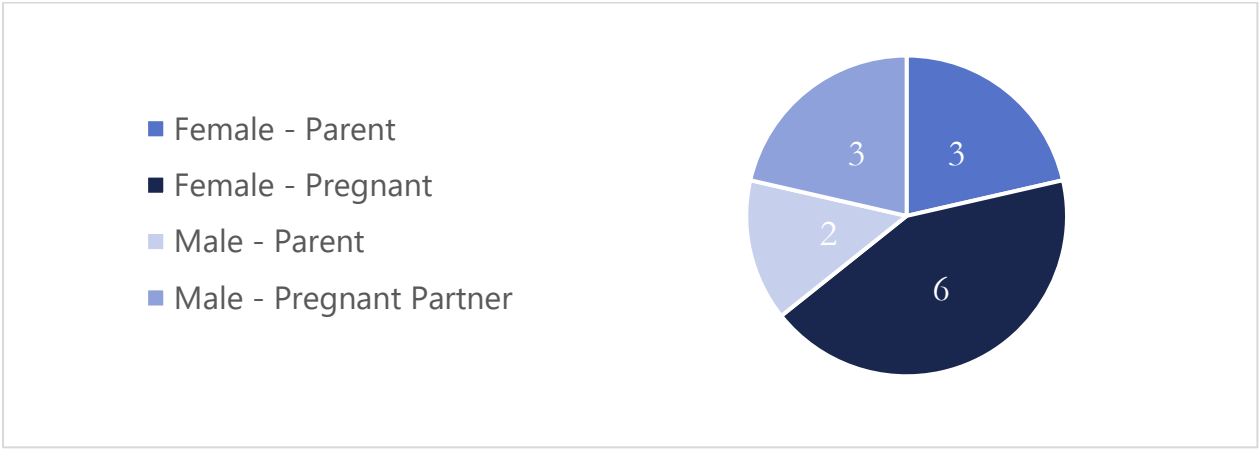
| # of items | Pre-Training (N = 32) | | Post-Training (N = 33) | |
|---|---|---|---|---|
| | # | % | # | % |
| 7 | 1 | 3.1 | 0 | 0.0 |
| 8 | 0 | 0.0 | 0 | 0.0 |
| 9 | 1 | 3.1 | 1 | 3.0 |
| 10 | 1 | 3.1 | 1 | 3.0 |
| 11 | 7 | 21.9 | 1 | 3.0 |
| 12 | 7 | 21.9 | 7 | 21.2 |
| 13 | 9 | 28.1 | 9 | 27.3 |
| 14 | 5 | 15.6 | 10 | 30.3 |
| 15 | 1 | 3.1 | 4 | 12.1 |
| Mean | 12.2 | | 13.1 | |

# Findings: Youth Interviews

## Youth characteristics

We interviewed 14 young people who attended a Risk Reduction training in Chicago. Nine were young women and five were young men. Five of the young people were already parents and nine were pregnant or had a pregnant partner.

**Figure 2. Pregnancy and Parenting Status**




## Learning about training

Most of the young people we interviewed learned about the training from their caseworker, from TPSN staff, or from staff at their TLP. However, one young woman learned about the training from her parenting coach and another learned about it from a sibling who had previously attended the training.

One young woman did not learn about the training until just before staff from her TLP took her to it. Another young woman did not learn about the training until her final D-CIPP meeting. She attended the training a month before her 21st birthday, when her child was 4.5 years old and preparing to enter kindergarten.

## Motivation to attend

Some of the young people we interviewed thought the training was voluntary. They attended the training because they wanted to learn more about caring for their newborns and become better parents.

> If there was a possibility that I could learn something different to better myself as a father, that's why I went.

Other young people thought the training was mandatory. Some of these young people stated that this was the only reason they attended the training. Others indicated that they would have attended even if it were voluntary because they wanted to learn how to take better care of their children.

Some young people appeared to be confused about the number times they needed to attend the training.[8] One young man reported being told that he would have to complete the training once a year. One young woman attended two of the trainings we observed but we were unable to interview her to find out why.

## Expectations

Some of the young people we interviewed did not have a clear set of expectations for the training. This included the young woman did not learn about the training until she was being driven to it and a young man who met weekly with a parenting coach. Other young people had a general sense of what to expect. They anticipated learning how to properly care for their child, how to put a crib together, and how to be an understanding parent. A few young people expected to learn about safe sleep and more generally about harm prevention. One young woman who was pregnant expected to learn about breastfeeding.

## Experiences with and lessons learned from training activities

With the exception of one young father, all the young people we interviewed reported learning valuable information. Below we describe what they reported learning from specific activities.

### Pack 'n Play

For young people who were not familiar with a pack n' play, putting one together was a valuable experience. One young woman noted that "if they didn't have the playpen [activity], I still wouldn't know how to put it up." Young people seemed to enjoy working together as part of a small group. One young woman reported feeling better when she realized she was not the only participant who didn't know how to put the pack n' play together and she liked working together with other participants to figure it out.

[8] During one of the trainings we observed, two young mothers who had brought their infants with them to the training left after a trainer recognized them as having already attended an earlier training.

## Safe Sleep

Many of the young people we interviewed reported learning several lessons about safe sleep.

> *I learned my son can't sleep in the car seat. I asked if I spend the night at my friend's house and like they don't have no place for the baby to sleep, and it was like, no, because it could mess up his neck.*
>
> *I had heard that you shouldn't keep you your baby in your bed, but I didn't know why. Now I do.*

One young woman said she was both surprised and disappointed to learn that co-sleeping is dangerous. Another noted that she had "never heard anything about killing the baby if you sleep with it." Others talked about how the training changed how they would put their baby to sleep. Specifically, they noted they would put their baby in a stable crib without covers or toys and would avoid co-sleeping. One young man stated that he was "never going to take naps with my child."

Several young people commented on what they learned from the Safe/Unsafe activity, which involves deciding if sleeping environments depicted in photographs are safe or unsafe for a baby. Some mentioned being surprised to learn that that having anything in a crib is dangerous because the cribs they see on television always have blankets and stuffed animals in them. Others noted that the picture of an infant in a dresser drawer generated a great deal of discussion. Young people seemed to like the discussion that occurred when there was disagreement over whether what was depicted in a particular picture was "safe" or "unsafe."

The Baltimore SIDS video was described by some young people as being particularly powerful.

> *The video was really sad, but really good. I learned don't put the baby to sleep on their tummy and not in the mommy's bed. They really cared for they babies, but they still died. It was good to hear about it from them that went through it.*

## Shaken Baby Syndrome

Shaken baby syndrome was another topic about which young people reported learning new information. The "mushroom soup" activity made a strong impression. Many of the young people we interviewed had not known that a baby's brain is soft and that its head is fragile. Seeing how easily the mushroom soup moved around the container helped them understand how fragile an infant's head is. Several of the young people noted that the video on shaken

baby syndrome made shaken baby syndrome "more believable" than if the trainers had just talked about it.

### Substitute Caregivers

Several of the young people we interviewed recalled learning about choosing a safe caregiver. Two young man reported that the vignettes about safely caring for children led them to rethink who their baby's substitute caregivers would be.

> *There was an article he was reading about a guy who was dating the baby's mom, some things about others who to leave your baby with. … It made me think about who to decide to let in my circle. As a father, I'm learning about who to leave my baby with. … If me and my siblings are butting heads, I won't leave my baby with them during that time.*
>
> *Before I thought I would leave her with my sister, but my sister gets annoyed. My people have short fuses. I don't think she would put her hands on my baby, but she might yell and that's not good. I don't want that negative energy around my baby.*

### Signs of Abuse

A number of young people also recalled learning about looking for signs of abuse. One remembered that bruising in certain places, such as the back and the head, could be a sign of abuse, while bruising in other places was normal.

### Parenting is Frustrating

Some of the young people reported learning that parenting is frustrating at times. One recalled being told that is normal for babies to say 'no' a lot. Another remembered being given ideas for how to calm a crying baby rather than yelling at or shaking it.

### Touch, Talk, Read, Play

Several young people talked about the talk, touch, read, play activity which uses play-doh to stimulate ideas about activities that promote baby brain development. Some liked this activity because it gave them ideas for things that they could do to promote the development of their baby's brain (e.g., reading, singing, talking) such as talking to the baby and pronouncing words deliberately. The mother of a 4 ½ year old identified this activity as the most relevant for her.

Other young people did not understand the purpose of the activity. One young person assumed it was a warm-up activity (even though it took place during the second half of the training). A

second described using the play-doh to make figures like snowmen.  A third thought that each color represented a different emotion (e.g. red for angry).  These young people probably attending the trainings during which the activity was neither explained nor executed well.

### Other Lessons

Several young people mentioned learning lessons from the training that were not tied to specific activities. One young woman described how training led her to rethink how she dresses her baby.

> *I learned something that I hadn't thought about it. You wouldn't want to go to sleep fully clothed, like fully clothed with shoes and all wrapped up, you'd get warm and so will they. When I go to sleep, I have my sleeping pjs on and that's it. Dress your baby as you would want to sleep at night.*

Another learned about the importance of taking care of herself.

> *They said it's ok to take care of yourself sometimes, it ok to do that. Your kids are going to need that too.*

Additionally, a few young women mentioned learning about the benefits of breastfeeding.

## Changes in caretaking behavior

We asked the five young people who were already parents when they attended the training if the training changed how they cared for their children. Four of the five said it did. Two mothers talked about knowing to step away when they are feeling impatient or when their baby is crying a lot.

> *My son does that [cries a lot] because he's teething real, real bad. … And I'm like, you know, I'm not even going to pick him up because I know my anger. … I check that he's ok in his crib, that he can't get to nothing, and then I walk out of the room so I don't get angry. I remember that video when my son was crying for no reason. I mean, you know, you make sure he's safe and then leave the room.*

Another mother explained how the training had an impact on how her son sleeps.

> *I'm really cautious of everything now. It made me more aware of things that could go wrong. He slept with his plush cover at the bottom of the pack 'n play when he goes with his dad and now he doesn't do that. I have people hold him different.*

The parent of the 4 ½ year old described how the YouTube clip shared in class of Ludacris rapping the words of a children's book had inspired her to find similar videos to watch with her child.[9]

## Satisfaction

Twelve of the 14 young people we interviewed reported being very satisfied with the training.

> *I learned everything. I thought it was going to be a boring, you know risk reduction, but it actually made me interested. I want to do it again.*

These young people valued the information the training provided and enjoyed participating in the hands-on activities. They liked that the facilitators answered their questions and did not feel that they were being judged. They appreciated that everyone had an opportunity to share their opinions. The young people who were pregnant found hearing from the peers who already had babies to be helpful. A few young people also said having materials to take home was beneficial.

Two young people reported being dissatisfied with the training. One young man who had fathered several children said he already knew everything and did not learn anything from it. Another young man, who described the training as "a waste of my time," felt that the trainer and the other participants did not take the training seriously and spent too much time joking. However, he planned to review the material he received at the training on his own.

## Recommendations for improvement

The young people we interviewed made recommendations for improving the training. Several young people suggested topics that could be added to the content of the training. One that seemed particularly relevant is age-appropriate discipline. Other suggested topics, such as breast-feeding and diaper changing, seemed better suited to a pre- or post-natal parenting class. In fact, one young man, who had a lot of questions after the training was over, wished that information about parenting classes had been provided as part of the training. Another young man suggested that the training should provide information about "daddy and me" groups.

Other recommendations were about process. Several young people recommended offering the training more frequently. One young woman was unable to attend the training until after her baby was born because no trainings were offered between when she learned about the training and when she gave birth. This sentiment was echoed by another young women who thought she would have benefit more from the training if she had attended while she was pregnant.

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[9] Available at: https://www.youtube.com/watch?v=PFtHeo7oMSU&list=LLH72K0NY9cge1Iu2pvc5gIw&index=25

One young man suggested that the trainings be co-ed so co-parents (or soon-to-be co-parents) could attend the training together. Other process-related recommendations included enforcing the "one speaker at a time" rule, requiring participants to raise their hands when they want to speak, and having young people eat either before or after the training because eating during the training was distracting.

## Recommend to a peer

All but one of the young people we interviewed indicated that they would recommend the training to a peer. In fact, even the young man who said he didn't learn anything from the training because he already knew all the material it covered made a point of saying that he would recommend the training to first-time parents. Below are some examples of what young people said they would tell a peer to recommend the training.

> *I took the class because I didn't know nothing about being a parent. It teaches you what not to do or what to do. It's free…It teaches you how to put a playpen together. It teaches you all the little things that you need to know.*

> *It's very educational. It tells you what to do with your child and be more confident in the things that you know.*

> *Especially for a first-time mom. A lot of people didn't know things. It wasn't judgmental. We could learn from each other.*

> *There are parents like me that don't know nothing about shaken baby syndrome and they should take the class.*

The only young person who would not recommend the training was the young man who felt that the other young men with whom he attended the training did not take it seriously.

# Findings: Trainer Interviews

We interviewed four trainers---two females and 2 males—and the training coordinator to learn what motivated them to become trainers, what successes and challenges they have experienced as trainers, and what their overall thoughts about the training are.

## Becoming a Risk Reduction Trainer

We asked the trainers why they became training facilitators. All the female trainers reported that they are required by the agencies for which they work to become training facilitators, but they are not required to facilitate any trainings. One of these trainers explained that she was already facilitating other trainings so it felt natural to facilitate the risk reduction training too. Another said that felt compelled to facilitate the training because there were few certified trainers in the region where she worked.

By contrast, neither of the male trainers reported that they were required to become training facilitators. One explained that he became a trainer because he wanted to provide additional support to the young men with whom he works. The other said that he was encouraged to become a trainer by his supervisor because he had a reputation for mentoring and building relationships with young men in care.

## Training Capacity

Trainers highlighted two issues related to training capacity: (1) certifying more trainers; and (2) willingness of certified trainers to facilitate the trainings. One trainer reported that some of the agencies that contract with DCFS to provide services to pregnant and parenting youth in care do not require their staff to become trained and/or facilitate the risk reduction training because it is not in their contract. She referred to this as "a missed opportunity" because more trainings could be held, and more youth could be trained, if more staff were certified to facilitate the training. Another trainer expressed that she thought there were enough trainers, but she noted that they don't volunteer to facilitate the trainings because doing so is not part of their job responsibilities and they receive no compensation for doing it. According to this trainer, "We have enough people who have been through the training, but we don't have enough people actually conducting the training."

According to the training coordinator, there has been a concerted effort to certify more trainers, particularly male trainers, over the past few years. TPSN was able to certify trainers in the Northern Region this past year, which will allow for additional trainings in that part of the state.

## Purpose of the Training

We asked the trainers what they understood the purpose of the training to be. Not surprisingly all the trainers talked about "reducing risk." One trainer viewed the training as a way "to get safety information out to every pregnant and parenting youth to prevent incidents." Another trainer described the training as an opportunity,

> *To help these kids think deeper about where they are putting their kids to sleep; who they are leaving their children with; and to identify when their children might be "acting bad," but it's just a developmental stage … and help them prepare for that and offset those challenges.*

This trainer highlighted the importance of teaching young parents about the potentially deadly consequences of co-sleeping and encouraging them to think about choosing appropriate substitute caregivers for their children. Another trainer noted that many young parents in care did not experience "good parenting" and the training provides a foundation on which they can build. One of the male trainers pointed out that, in addition to educating young fathers about risk and safety, the training also offers young fathers a forum to ask questions about caring for their babies.

## Engaging Participants

Trainers agreed that engagement is key to a "good training" and described a number of strategies they use to engage youth. These include starting with the ice breaker which allows participants to interact and become comfortable with one another, requiring participants to move around rather than remain seated, making eye contact with participants, and posing questions to more reserved participants in order to "pull them in."

Trainers noted the level of engagement often depends on the size of the group. Participants may be unwilling to talk in groups that are too small and or too large, and hence, chaotic. Although there was no consensus on what the size of the group should be, trainers did agree that a group is the "right" size if participants can reflect on the content of the training unselfconsciously, engage in healthy debate and conversation, and have time to ask questions about topics of interest to them.

Another factor that can affect engagement is the dynamic that develops within the group. One trainer talked about the sense of camaraderie that sometimes develops when participants who are already parenting share their experiences with participants who are pregnant. Trainers also note that the vignettes participants read can lead to lively discussions. According to one trainer, "If you have a good group, you have a debate and they lead the discussion…They start to engage on their own and you can just prompt them."

The trainers agreed that they "start to lose participants" during the final activity (i.e., Seven Deadly Sins). Some attributed this to the timing of the activity; others attributed it to the length of the activity or the fact that it is not particularly interactive.

## Segregating Training by Gender

Young women and young men are typically trained separately.[10] The trainers we interviewed offered several justifications for this practice. One trainer suggested that young people feel freer to talk about their partners (e.g., 'he doesn't like to do this' or 'he wants me to do that") when members of the other gender are not in the room and that single gender trainings create a safe space in which to talk. Another trainer noted that when males and females have been trained together, some of the activities---particularly those that involving reading and discussing a vignette---turned into "blame games." The young women debated the young men about which character was at fault rather than focusing on the safety issues that the vignette raises.

However, some trainers reported that co-parents have become upset upon learning that they would not be trained in separate rooms. One of these trainers recommended that training sessions specifically for co-parenting be offered.

## Gender Differences in Trainings

Several of the trainers made observations about differences between the young women and young men who participate in the training. One trainer noted that male participants seem to really enjoy the training, perhaps because they have few opportunities to come together to talk and learn about parenting. Another trainer noted that female participants also seem to enjoy the training but are more accustomed to having discussion about parenting.

A couple of trainers highlighted some of the differences between the materials that are used during the training for young women and the training for young men. Both pointed to the differences between the Baltimore B'more for Healthy Babies Safe Sleep video that the young women view and the Baltimore safe sleep video that the young men view.

> *The male video has a group of guys at the barbershop and they are talking about what fatherhood means to them, but the female video is a group of women who lost their children to SIDS. You can see the difference in the two [videos]. It's hard to describe, but those two videos kinda give understanding into why they separate them and why they give the females different views than they give the males.*

[10] Exceptions to this practice can be made. For example, if only one young man shows up, he should be included in the training for young women.

One of these trainers described the video shown to the young men as "upbeat" and as making young men "proud to be a parent." By contrast, he described the video shown to the young women as being sad. Time permitting, this trainer shows both videos to the young men he trains and recommends that other trainers who train young men do the same. However, he cautioned against showing both videos to the young women because they might question why the tone of the fatherhood video is so much more upbeat.

This same trainer also highlighted differences between the stories that the young women and young men read in the *Taking Care of Our Baby* booklet. Typically young men read the story about Marcus and Dennis, which involves a youth in care finding his child crying at his baby's mother's boyfriend's apartment and avoiding an altercation with the boyfriend, while the young women read the story about Susan, in which Susan is cautioned about her boyfriend's temper and finds her child severely beaten. This trainer usually includes Susan's story in his trainings because it touches on the subject of domestic violence. He asks participants to think about the advice they would give to Susan if she were a cousin or friend. In his experience, both stories generate robust discussions and he recommends that both be included in the training for young men.

## Gender Differences in Attendance

A couple of the trainers noted differences between which young men and which young women attend the training. One trainer observed that young men generally attend the training if their partner is in care while young women whose partner is in care don't attend the training. She hypothesized that young women who are not in care don't want DCFS to know who they are or anything about them. Another trainer explained that he instructs the young men in his TLP who are required to attend the training to invite their partners so that both parents will be exposed to the safety information.

## Challenges

The primary challenge trainers mentioned was childcare, and their perspectives on providing childcare during the training varied. One trainer reported that participants are always told to find childcare but acknowledged that some young mothers won't attend if they can't bring their babies. Because most newborns just sleep through the training, this trainer allows participants to keep their babies in the room. This trainer never had the experience of a participant bringing a toddler to the training. Another trainer encourages participants to bring their children to the training and arranges for volunteers to provide childcare.

One trainer identified getting youth to participate in the training as a challenge. She attributed this to the fact that they are teenagers and "don't want to do anything." This trainer recounted how one young woman refused to enter the building where the training was taking place after

being dropped off by her caseworker or foster parent. Although the trainers were eventually able to convince her to come inside and have something to eat, she turned her chair away from the group and refused to participate.

## Recommendations for improvement

The trainers offered several suggestions for improving the training. These included:

- Shortening the training, specifically by dropping the play-doh activity and/or the seven deadly sins activity
- Updating the pictures used in the safe versus unsafe sleep activity
- Including a copy of *A Helpful Guide for Parents and Caregivers* in the folder that participants receive[11]
- Adding topics such as breastfeeding or post-partum depression that a parenting class would typically cover and inviting guest speakers to cover those topics
- Making the developmental stages activity more interactive
- Offer the training to all young adults in DCFS care, not just to those who are pregnant or parenting
- Provide a $25 incentive to encourage participation.

[11] Available at: https://www2.illinois.gov/dcfs/safekids/safety/Documents/CFS_1050-69_OIG_Helpful_Guide.pdf

# Findings: Analysis of DCFS Allegations Data

We used the DCFS child maltreatment data to examine child abuse and neglect allegations involving children who were born on or after July 1, 2011, the date on which the Risk Reduction training was launched. Only allegations that were made prior to a child's first birthday were included. Results are presented separately for parents who completed the training and for parents who did not.

Table 8 shows the number and percentage of parents who were investigated for at least one allegation. Forty-three percent of the parents who completed the training were investigated for at least one allegation compared to 29 percent of parents who did not complete the training. Additionally, nearly all the investigations involved allegations of neglect.

**Table 8. Parents with Allegations by Allegation Type**

| | Completed (N = 756) | | Did Not Complete (N = 583) | |
|---|---|---|---|---|
| | # | % | # | % |
| Any allegation | 325 | 43.0 | 171 | 29.3 |
| Any allegations of neglect | 313 | 41.4 | 163 | 28.0 |
| Any allegations of physical abuse | 66 | 8.7 | 35 | 6.0 |

Table 9 shows the number of parents who were investigated for different allegations of neglect. By far, the two most common neglect allegations for both groups of parents were substantial risk of physical injury by neglect (allegation 60) and lack of supervision (allegation 74).

### Table 9. Neglect Allegations

| | Completed (N = 313) | Did Not Complete (N = 163) |
|---|---|---|
| Substantial Risk of Physical Injury | 254 | 137 |
| Inadequate Supervision | 97 | 45 |
| Environmental Neglect | 36 | 13 |
| Medical Neglect | 34 | 15 |
| Inadequate Food | 20 | 11 |
| Inadequate Shelter | 15 | 8 |
| Failure to Thrive | 7 | 2 |
| Inadequate Clothing | 7 | 1 |
| Cuts, Bruises, Welts, and Abrasions | 6 | 1 |
| Substance Misuse | 5 | 9 |
| Abandonment/Desertion | 5 | 1 |
| Burns | 5 | 1 |
| Death by Neglect | 3 | 4 |
| Head Injuries | 2 | 0 |
| Bone Fractures | 1 | 1 |
| Malnutrition | 0 | 1 |

Table 10 shows the number of parents who were investigated for different allegations of physical abuse. By far, the most common physical abuse allegation for both groups of parents was substantial risk of physical injury (allegation 10).

### Table 10. Physical Abuse Allegations

| | Completed (N = 66) | Did Not Complete (N = 35) |
|---|---|---|
| Substantial Risk of Physical Injury | 54 | 28 |
| Cuts, Bruises, Welts, and Abrasions | 13 | 3 |
| Substance Misuse | 3 | 0 |
| Bone Fractures | 2 | 3 |
| Burns | 1 | 0 |
| Death | 1 | 0 |
| Head Injuries | 0 | 1 |
| Human Bites | 0 | 1 |

Table 11 shows the number and percentage of parents with at least one indicated allegation. Twenty-six percent of the parents who completed the training had an indicated allegation compared to 18 percent of parents who did not complete the training.

**Table 11. Indicated Allegations by Allegation Type**

| | Completed (N = 756) | | Did Not Complete (N = 583) | |
|---|---|---|---|---|
| | # | % | # | % |
| Any allegation | 194 | 25.7 | 103 | 17.7 |
| Any allegations of neglect | 174 | 23.0 | 95 | 16.3 |
| Any allegations of physical abuse | 16 | 2.1 | 14 | 2.4 |

Table 12 shows the number of parents with indicated allegations involving different forms of neglect. The two most common indicated neglect allegations for both groups of parents were substantial risk of physical injury by neglect (allegation 60) and lack of supervision (allegation 74).

**Table 12. Indicated Neglect Allegations**

| | Completed (N = 174) | Did Not Complete (N = 95) |
|---|---|---|
| Substantial Risk of Physical Injury | 132 | 84 |
| Inadequate Supervision | 20 | 17 |
| Medical Neglect | 6 | 3 |
| Failure to Thrive | 4 | 0 |
| Environmental Neglect | 3 | 2 |
| Inadequate Food | 3 | 1 |
| Burns | 2 | 1 |
| Substance Misuse | 1 | 9 |
| Inadequate Shelter | 1 | 2 |
| Death | 1 | 1 |
| Abandonment/Desertion | 1 | 0 |
| Bone Fractures | 0 | 1 |
| Malnutrition | 0 | 1 |

Table 13 shows the number of parents with indicated allegations involving different forms of physical abuse. The only physical abuse allegation that was common among both groups of parents was substantial risk of physical injury (allegation 10).

### Table 13. Indicated Physical Abuse Allegations

| | Completed (N = 16) | Did Not Complete (N = 14) |
|---|---|---|
| Bone Fractures | 0 | 2 |
| Cuts, Bruises, Welts, and Abrasions | 2 | 0 |
| Substantial Risk of Physical Injury | 12 | 14 |

# Discussion and Recommendations

## Discussion

We evaluated the Risk Reduction training that was developed by the Office of the Inspector General to reduce infant mortality among the children born to youth in care. We observed training sessions, administered pre- and post-training questionnaires, analyzed TPSN program data and DCFS administrative data, and interviewed young people who participated in the training and trainers who facilitate the sessions. We summarize the main findings from each of the study's components below.

*TPSN Program Data*: Between July 1, 2011, when implementation of the Risk Reduction training began, and November 13, 2018, the last date for which we received data from TPSN, 1,339 youth in care were eligible to participate in the training. The training was completed by 57 percent (N = 756) of those youth. We do not know why 43 percent of the youth who were eligible for the training did not complete it, although young women were about twice as likely to complete the training as young men. Thirty six percent of the youth who completed the training did so before the birth of their first child who was born after July 1, 2011, 58 percent had completed the training within three months of their child's birth and 85 percent had completed the training by their child's first birthday,

*Training Observations*: The young people who attended the trainings were generally engaged in the activities, but often failed to adhere to the ground rules they had agreed to at the beginning of the session. Trainers did not always explain the purpose of the training, moved from one activity directly into another without providing any context, and did not synthesize the material covered at the end of each component. Additionally, the same activities were facilitated differently by different trainers and not all participants had an opportunity to participate in all of the activities.

*Pre- and post-training questionnaires*: We found a statistically significant increase in participants' knowledge about the material covered by the training, as measured by the number of items answered correctly on a brief questionnaire. The biggest increase we observed was in the percentage of participants who correctly indicated that having blankets in a crib with their infant is unsafe.

*Youth interviews*: Several of the young people we interviewed lacked a clear understanding of the training's purpose and they came to the training with different expectations as to what would be covered. Some were under the impression that the training was voluntary whereas others were informed that they were required to attend. All but one young person reported learning valuable lessons about topics such as safe sleep and SIDS, shaken baby syndrome, choosing an appropriate caregiver and signs of abuse, and some reported being surprised by

what they learned. Most of the young people who were already parents reported that the training led them to changing how they cared for the children. All but two of the youth reported being very satisfied with the training and all but one would recommend the training to a peer.

*Trainer interviews:* The trainers we interviewed noted that training capacity was limited because there are too few certified trainers and those who are certified are not always willing to facilitate the trainings. Trainers agreed that engagement is key to a "good training" and described a number of strategies they use to engage youth. They also identified the number of participants and the dynamic that develops within the group as factors that affect engagement. Trainers noted that the training is an opportunity for young people to come together to ask questions about parenting and spoke about the challenges posed by participants' need for childcare. Trainers shared their perspectives on why young women are trained separately from young men and highlighted gender differences in the training materials.

*DCFS Administrative Data*: Our analysis of child abuse and neglect allegations found that parents who completed the training were both more likely to be investigated for at least one allegation of child maltreatment (43% vs. 29%) and more likely to have at least one indicated allegation (26% vs. 18%) than parents who did not complete the training. Additionally, regardless of whether parents had completed the training or not, nearly all the allegations—and nearly all the indicated allegations---involved neglect, primarily substantial risk of physical injury and inadequate supervision.

The higher rate of allegations and indicated allegations among parents who completed the training than among parents who did not seems counter-intuitive. Although the risk reduction training was not designed to prevent all types of child maltreatment, it seems unlikely that the training would increase child maltreatment among those who complete. A more plausible explanation is that parents who completed the training were, as a group, different from the parents who did not complete the training, and that this difference put them at higher risk for maltreating their children. For example, even though the training is supposed to be completed by all youth in care who are pregnant or parenting, it is possible that some caseworkers or child welfare agency staff only referred youth whose risk for maltreatment was perceived to be high. Alternatively, some caseworkers or child welfare agency staff may have referred all youth who were supposed to complete the training but made more of an effort to ensure that those youth about whom they were most concerned attended one of the sessions.

One way to test this hypothesis would be to use scores on the Adult Adolescent Parenting Inventory (AAPI) which is completed as part of the New Birth Assessment. The AAPI scores of youth who completed the training could be compared to the AAPI scores of youth who did not to see if the youth who completed the training appear to be at higher risk. Another option would be talk to youth and caseworkers to better understand why some eligible youth complete the training and other eligible youth do not.

It is also worth highlighting the fact that just over a third of the youth who completed the training did so before their child was born. Although 58 percent had completed the training by the time their child was three months old, 15 percent did not complete the training until after

their child's first birthday. For the training to have an impact on infant mortality, parents need to complete the training before the birth of their child or very shortly thereafter.

## Recommendations

Below we offer recommendations for ways in which the Risk Reduction training could be improved. These recommendations are based on both our observations of the trainings and our interviews with certified trainers and with youth who attended one the trainings we observed. Most fall into five broad categories: informing youth about the training, preparing for the training, facilitating the training, revising the curriculum, and providing additional resources.

### Informing youth about the training

- Clarify in policy which youth are required to attend the training, when those youth should be informed about the training and who is responsible for providing that information.
- Develop flyers or other materials for youth that provide information about the purpose of the training and the topics the training will cover so that youth know what to expect.
- Clearly communicate to youth who are required to attend the training that they only need to attend the training once, that they must arrive on time to receive credit for attending, and that their partners who are not in care are welcome, but not required, to attend.

### Preparing for the training

- Confirm that youth who are registered for the training will be attending for the first time and notify youth who have already completed the training that they do not need to attend.
- Determine if any youth will be bringing their children to the training, and if so, arrange for staff to be available to provide childcare in a separate room.
- Notify caseworkers or other child welfare staff who will be transporting youth to the training that youth are expected to arrive on time.
- Create name tents for participants and name tags for trainers so that participants and trainers can refer to one another by name.

### Facilitating the training

- Remind participants to adhere to the ground rules agreed to at the beginning of the training such as not talking over one another.
- Begin the training with a brief explanation of why the training was developed and a clear statement of the training's objectives.
- Provide trainers with talking points for each activity to ensure that important points are always covered.
- Clarify the order in which the vignettes should be read and discussed.

- Give all youth an opportunity to participate in each activity (including the safe/unsafe sleep pictures activity).
- Offer breaks or engage participants in a short but fun activities to refocus their attention if they appear restless, fatigued, or disinterested.
- Wrap up the training with a review of the objectives and the major takeaways.

### Revising the curriculum

- Update the pictures used in the safe versus unsafe sleep activity and engage participants in a discussion of whether what the pictures depict is safe or unsafe.
- Show all participants both B'more for Healthy Babies videos.
- Allow partners who plan to co-parent or who are co-parenting to attend designated training sessions together.

### Providing additional resources

- Give all participants a copy of the OIG's *Helpful Guide for Parents and Caregivers*.
- Include information about pre- or post-natal parenting classes, home visiting programs, parent/child programs for parents with infants/toddlers, and parent helplines in the packets participants receive.