

# Explaining Risk Factors for Successful Family Supervision Orders: Families with Intellectual Disabilities in Child Protection in the Netherlands

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## Abstract

Families with mild to borderline intellectual disabilities (MBID) are overrepresented in child protection, and are at higher risk for long and unsuccessful family supervision orders (FSOs). This is worrisome, as many children apparently are exposed to unsafe parenting situations for longer periods of time. Therefore, the present study examined which child and parental factors and child maltreatment are related to the duration and success of an FSO in families with MBID in the Netherlands. Casefile data were analysed of 140 children with an ended FSO. Results from binary logistic regression analyses showed that in families with MBID, young children, children with psychiatric problems, and children with MBID were at higher risk for a longer duration of FSOs. Furthermore, young children, children with MBID and children who were sexually abused had a lower chance of a successful FSO. Unexpectedly, children who witnessed domestic violence or whose parents were divorced, had a higher chance of a successful FSO. The discussion focuses on implications of these results for treatment and care of families with MBID from the perspective of child protection.

## Keywords

Child protective services, parenting, disability, child maltreatment, risk factors

Child maltreatment is a worldwide problem and has an enormous impact on children's wellbeing: it can lead to severe physical, psychological and neurobiological harm (Vink et al., 2020). Because of these potentially serious consequences, it is important that children be protected from it, as is also stated in Article 19 of the Convention on the Rights of the Child (United Nations Convention on the Rights of the Child, 1989). In cases of maltreatment, the government must act. One way to intervene when a child's safety is in jeopardy is by imposing a child protection order.

In the Netherlands, the most common child protection measure is the family supervision order (FSO). An FSO is a compulsory, temporary child protection measure, to protect the child and to support the parents. An FSO can be imposed by a judge for a maximum of 1 year (Person and Family Rights, 2021a). When safety conditions are not achieved within this year, the FSO can be extended repeatedly for a maximum of 1 year (Person and Family Rights, 2021b). The FSO can be issued up to the child's age of 18 years. During the FSO, the parents retain custody of their child, although they must accept compulsory care, imposed by the family supervisor. The coordination and supervision of care provided by

family supervisors is part of a case management approach; they do not provide the help themselves. Finally, the premise of an FSO is that children live at home with their parent(s) during the supervision period.

In addition to an FSO, which is the most common child protection measure, there are two other measures in the Netherlands: out-of-home placement and state custody. If safety conditions are not achieved within a certain period of time, or when a child is at immediate risk, the judge can decide to (temporarily) place a child out of its home (Person and Family Rights, 2021c). An out-of-home placement is not a standard procedure within an FSO, but can be imposed if the child's safety cannot be adequately realized during the FSO.

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Furthermore, as a ‘last resort’, if parents are continuously unable to take responsibility for the care and upbringing of their child, parental authority can be terminated and state custody can be issued (Person and Family Rights, 2021d).

Even though the FSO is intended as a temporary measure, and imposed for a maximum of 1 year, Dutch national figures show that in 2021 60% of the FSOs lasted longer than 1 year (Central Bureau for Statistics, 2022). Research by Busschers et al. (2016) found that on average FSOs lasted longer than 3 years, and notably, more than half of the children were placed out of their homes during the FSO. This is worrisome because it indicates that, even during an FSO, many children are exposed to unsafe parenting situations for extended periods of time. Moreover, a study by Slot et al. (2001) on the effects of an FSO showed that after a 2-year FSO, there was no improvement in the number of concerns about the child and the family, and in 33% of the cases, the situation actually worsened.

Previous research has shown that especially parents and/or children with mild to borderline intellectual disabilities (MBID), who have problems in cognitive and adaptive functioning (Schalock et al., 2021) (further referred to as families with MBID), are overrepresented in child protection services (e.g., Booth et al., 2005; Dion et al., 2018; McConnell et al., 2011b; 2011a; 2021; Willems et al., 2007), and are more likely to have longer and more complex child protection trajectories (Dion et al., 2018; McConnell et al., 2011a; 2021). The odds of children being removed from their parents and getting involved with ongoing child protection services are significantly higher for families with MBID (e.g. Dion et al., 2018; McConnell et al., 2021; McGaw et al., 2010). Once children with MBID have been placed out-of-home, they are also more likely to be exposed to placement instability, such as frequent moves or placement in institutions (Konijn et al., 2019; Slayter & Springer, 2011; Slayter, 2016). In addition, after child protection involvement, children with MBID were receiving more follow-up services and were more likely to be re-referred to child protection again (Dion et al., 2018). These findings suggest that, in families with MBID, there is a greater risk for FSO trajectories to exceed the limit of 1 year, and out-of-home placement of children during the FSO. In other words, families with MBID seem to be at an increased risk for unsuccessful trajectories.

In the current study, we distinguish between an unsuccessful FSO and a successful FSO. According to Dutch civil law an FSO is intended as a temporary measure, which means that safety of the child should be increased as soon as possible. Notably, Slot et al. (2001) found that there was no improvement after a 2-year FSO. Therefore, we defined an unsuccessful FSO as a long trajectory (longer than 2 years) where severe care is necessitated at the end of the FSO, such as temporary or permanent out-of-home placement, and termination of parental authority if parents have shown to be unable or unwilling to act in the best interests of their child. Successful FSOs, on the other hand, are short (less than 2 years),

with the child living at home at the end of the FSO, if necessary with voluntary care.

To date, little is known about factors related to the duration and success of an FSO, especially concerning families with MBID. In order to minimize the unsuccessful FSO trajectories, it is important to gain a better understanding of the factors that are associated with the duration and success of an FSO in these families. With this knowledge, child protection services may be better able to improve the provided care, which could result in an increased likelihood for families with MBID to regain full responsibility for the upbringing of the child.

Only a few studies focused on factors that might explain the duration of an FSO. Busschers et al. (2016) examined the duration of FSOs in 224 families with a child protection measure in the Netherlands. It was found that most of the variance in FSO duration (87%) could be explained by case characteristics such as provisional supervision order, out-of-home placement during FSO, higher age of the child at start of FSO, concrete formulated parenting goals, and number of involved case managers. The remaining part (13%) was explained by case manager characteristics such as working experience and method integrity. Glisson et al. (2000) examined which factors explained the time children spent in state custody in a sample of 700 children in the United States. They found that the probability of leaving state custody was lower for children with mental health problems, disabilities, African-American origin, children who experienced sexual abuse, children from rural countries, and children who were in custody due to parental substance abuse and neglect.

The studies of both Glisson et al. (2000) and Busschers et al. (2016) did not examine whether above mentioned factors explain *successful* FSOs, and whether these factors also apply to families with MBID. Moreover, the child protection system in the USA can differ from the Netherlands in certain respects, such as the availability of particular youth or family interventions, the degree to which (costless) legal support is available for children and parents, and legal conditions for the application of FSOs (e.g. Cameron & Feymond, 2016; Child Welfare Information Gateway, 2013; Gilbert, 2012). Despite these differences, the two systems show many similarities (Albright et al., 2019) as both systems involve a case management approach, where caseworkers arrange and coordinate care to achieve child safety, first and foremost within the home of the family (Capacity Building Center for States, 2018). Therefore, cross-cultural comparisons and generalizing results from one country or continent to another seem warranted, although caution remains needed.

People with MBID generally experience more difficulties in understanding abstract concepts, and tend to have more problems with information processing (Kail, 1992; Van der Molen et al., 2007). As a result, they need more time to learn, and, also in adulthood, continuous and longer support is needed to master new (parenting) behaviour (Azar et al., 2012, 2016). In addition to their intellectual disability, people with MBID are more likely to experience emotional, behavioural,

psychiatric problems, and/or substance abuse than people without MBID, which adds to their vulnerability (e.g. Einfeld et al., 2011; Peña-Salazar et al., 2018; Slayter et al., 2019).

There is empirical evidence showing that children with MBID experience more negative life events, or adverse childhood experiences (ACEs) (Vervoort et al., 2018). Felitti et al. (1998) were the first to demonstrate the impact of ACEs on mental and physical health in adulthood. Their framework included experiences of abuse (physical, psychological and sexual) and household dysfunction (mental health problems, substance abuse, domestic violence and imprisonment of parents). Subsequent studies added neglect (physical and psychological) and parental separation to this framework (e.g. Bellis et al., 2013; Bethell et al., 2017; Kalmakis & Chandler, 2015).

Traumatic experiences in childhood are a dominant factor that impact the functioning of parents with MBID and the quality of their parenting (McGaw, 2010). As a consequence, these problems increase the stress in parents, which in turn can lead to negative parenting styles and problematic family functioning (Emerson et al., 2011; Fenning et al., 2007; McConnell et al., 2011a, 2011b) and, subsequently, to neglect and abuse (Euser et al., 2010; Hindmarsh et al., 2017). These cycles of multi-problems may contribute to longer and unsuccessful FSOs.

Therefore, it is crucial to increase our knowledge of factors that are related to the duration and success of an FSO in families with MBID. Accordingly, this study will examine which child factors (MBID, behavioural- and psychiatric problems, and substance abuse), parental factors (MBID, mental health problems, psychiatric problems, substance abuse, imprisonment, poor parenting skills, traumatic past, and divorce) and maltreatment factors (abuse and neglect, sexual abuse and domestic violence) are related to the duration and success of FSOs in families with MBID.

## Method

### Sample

In this casefile study, data of 140 children were analysed (56% male, 44% female), between the ages of 0 and 18 years, with an ended Family Supervision Order (FSO) that was executed by a child protection service organization in the Netherlands, specialized in working with families (i.e. children and/or parents) with MBID. All families had a child and/or parent with a disability. However, the included child in this study was not always the one with an MBID, it could also be a sibling with an MBID. In this study, at least 57% of the children had an MBID, and 64% of the parent(s) had an MBID. Six participants were unborn babies at the start of the FSO. The mean duration of the FSO was 3.67 years, with a minimum of 90 days and a maximum of 15.87 years. At the start of the FSO, 73.9% of the children lived at home with their parent(s), and 26.1% of the children lived in either residential facilities or

foster care. Before the data collection started, two children were excluded, because of a blank casefile. The first three columns of Table 1 provide an overview of the prevalence of the explaining factors and outcomes of the sample.

The selection of files was based on the inclusion criterion that the FSO had to have ended between 2015 and 2019, as to include the most recent cases from the past 5 years for sufficient quality of the casefiles, and because of new legislation of child protection care in the Netherlands in 2015 (see for more information <https://www.nji.nl/english/introduction-dutch-youth-policy>). Of all children who were in care at time of sampling, a total of 4184 casefiles met the inclusion criterium. From these 4184 casefiles a random sample of 150 casefiles was drawn by means of an online randomizer.

### Procedure

Data were collected by using information from the participants' files. In the period December 2019 to August 2020, the files were coded using a structured coding system, which was also partly used in a previous study by Vervoort et al. (2018). The casefiles were coded at start and end of the FSO. Information used for this study included council reports, court orders, standardised internal reports (i.e., FSO intervention plan, and risk- and safety assessments) and external (youth care) reports. The files were coded by the first and fourth author and master students of (forensic) child and youth care studies, who all received a 1-day training in using the coding system. In addition, the students participated in weekly intervision meetings. The data were pseudonymized so that the datasets did not contain any traceable information. The study procedure was approved by the Ethics Review Board of the University of Amsterdam (case number: 2019-CDE-10,129).

### Measures

The definitions and criteria for the variables were defined in the coding system (see Table 2 for an overview of the variables used in the current study). Inter-rater reliability was calculated by reassessing 20% of the scored files. Cohen's Kappa (K) was calculated across 18 variables and was .79, indicating a high degree of inter-rater reliability (Allen et al., 2014).

**Explaining factors.** Each variable was coded with 'yes' (1) if the information in the casefile matched the criteria as operationalized in the coding instrument. The variable was coded with 'not described in file' (0) if the variable was not present in the child and/or parents based on the information in the file, or if the information was not present in the file. Age of the child was not normally distributed and, therefore, divided into three categories: early childhood (0–5 years), middle childhood (6–11 years) and adolescence (12–18 years). Two dummy variables were made with adolescence as reference. Furthermore, some of the variables were not relevant for children of a certain

**Table 1.** Descriptives and Chi-squared tests of child, parental and maltreatment factors and outcomes for gender and age of the child.

Factors	N	% <i>(n)</i> <sup>a</sup>	Gender			Age			
			Male % <i>(n)</i>	Female % <i>(n)</i>	$\chi^2$ <sup>b</sup>	Early Childhood % <i>(n)</i>	Middle Childhood % <i>(n)</i>	Adolescence % <i>(n)</i>	$\chi^2$ <sup>b</sup>
<b>Child factors</b>									
Behavioural problems	120	84.2% (101)	82.1% (55)	86.8% (46)	.49	70.0% (21)	75.7% (28)	98.1% (52)	14.26***
Psychiatric problems	108	43.5% (47)	43.3% (26)	43.8% (21)	.02	33.3% (6)	29.7% (11)	56.6% (30)	7.31*
Substance abuse	68	20.6% (14)	15.8% (6)	26.7% (8)	1.21	-	7.1% (1)	24.5% (13)	2.28
Intellectual disability	138	56.5% (78)	51.9% (40)	62.3% (38)	1.48	27.1% (13)	62.2% (23)	79.2% (42)	28.54***
<b>Parental factors</b>									
Mental health problems	138	88.4% (122)	89.6% (69)	86.9% (53)	.25	91.7% (44)	89.2% (33)	84.9% (45)	1.15
Psychiatric problems	138	47.8% (66)	48.1% (37)	47.5% (29)	.00	47.9% (23)	59.5% (22)	39.6% (21)	3.44
Substance abuse	138	34.8% (48)	36.4% (28)	32.8% (20)	.19	41.7% (20)	35.1% (13)	28.3% (15)	1.99
Intellectual disability	138	64.5% (89)	62.3% (48)	67.2% (41)	.35	79.2% (38)	62.2% (23)	52.8% (28)	7.75*
In prison	138	13.0% (18)	18.2% (14)	6.6% (4)	4.06*	18.8% (9)	18.9% (7)	3.8% (2) <sup>c</sup>	6.52*
Poor parenting skills	138	95.7% (132)	93.5% (72)	98.4% (60)	1.93	97.9% (47)	86.5% (32)	100.0% (53)	10.48**
Traumatic past	138	58.7% (81)	59.7% (46)	57.4% (35)	.08	72.9% (35)	56.8% (21)	47.2% (25)	6.97*
Divorce	138	72.5% (100)	71.4% (55)	73.8% (45)	.09	64.6% (31)	78.4% (29)	75.5% (40)	2.38
<b>Maltreatment factors</b>									
Abuse and/or neglect	138	86.2% (119)	81.8% (63)	91.8% (56)	2.86	79.2% (38)	86.5% (32)	92.5% (49)	3.75
Sexual abuse	138	18.1% (25)	7.8% (6)	31.1% (19)	12.52***	.0% (0)	21.6% (8)	32.1% (17)	17.89***
Domestic violence	138	77.5% (107)	74.0% (57)	82.0% (50)	1.23	68.8% (33)	78.4% (29)	84.9% (45)	3.80
<b>Outcome</b>									
Duration FSO (long)	138	58.0% (80)	51.9% (40)	65.6% (40)	2.59	66.7% (32)	56.8% (21)	50.9% (27)	2.59
Successful FSO <sup>c</sup>	98	30.6% (30)	33.3% (18)	27.3% (12)	.42	22.5% (9)	28.6% (8)	43.3% (13)	3.58

<sup>a</sup>Percentages of the present child, parental and maltreatment factors.

<sup>b</sup>*df* = 1.

<sup>c</sup>Fishers Exact Test was interpreted.

\**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

age. These variables were only coded when children had a certain minimum age: behavioural problems if the child's age was 1.5 years or older (*n* = 120), psychiatric problems if the child's age was 4 years or older (*n* = 108), and substance use if the child's age was 6 years or older (*n* = 68).

**Outcome variables.** The duration of the FSO was dichotomized into: "shorter than 2 years" (0) and 'longer than 2 years' (1). The success of an FSO was also divided into two categories: 'unsuccessful' (0) and 'successful' (1). Unsuccessful referred to FSOs with a duration shorter than 2 years and a different, permanent, measure at the end of FSO (such as permanent out-of-home placement

and/or termination of parental authority); or a duration longer than 2 years. Successful referred to FSOs with a duration shorter than 2 years, with the child living at home at the end of an FSO, if necessary with voluntary care.

### Data-analysis

All statistical analyses were carried out using SPSS, version 25. First, chi-square tests were conducted to examine the relations between age and gender of the child on one hand, and the explaining child, parental and maltreatment factors on the other hand, to find out whether there were gender and

**Table 2.** Overview and definition of the child, parental and maltreatment factors and outcomes.

Factors	Definition
<b>Child factors</b>	
Behavioural problems	Child shows internalizing (anxious and withdrawn behaviour, physical symptoms without a somatic condition) and/or externalizing (aggressive behaviour, oppositional behaviour, and anti-social behaviour) problems
Psychiatric problems	The child has one or multiple (presumable) DSM diagnoses
Substance abuse	The child abuses substances, such as drugs or alcohol
MBID	The child has a (presumed) intellectual disability (IQ-score <85 and limitations in adaptive functioning)
<b>Parental factors</b>	
Mental health problems	One or both biological parents has (had) mental health problems or suicide thought(s) and/or has (ever) attempted suicide, during the life of the child
Psychiatric problems	One or both biological parents has one or multiple (presumable) DSM diagnoses
Substance abuse	One or both biological parents abuses substances, such as drugs or alcohol
MBID	One or both biological parents has an (presumed) intellectual disability (IQ-score <85 and limitations in adaptive functioning)
Imprisonment	One or both biological parents has ever been in prison (during child's life)
Poor parenting skills	One or both biological parents has poor parenting skills, an inconsistent parenting style and/or imbalance of the parenting capacity and parenting load
Traumatic past	One or both biological parents have had to deal with a traumatic past
Divorce	Separation or divorce of biological parents
<b>Maltreatment factors</b>	
Abuse and/or neglect	The child has ever been exposed to emotional/physical abuse and/or neglect by the caregiver. Emotional abuse: Non-incident hostility or rejection toward the child. Emotional neglect: Non-incident fail of the parent(s) to be responsive and give positive attention. Physical abuse: All forms of physical violence against the child. Physical neglect: parent(s) fail to, adequately, provide for the child's basic necessary needs
Sexual abuse	The child has past or current experiences of sexual abuse
Domestic violence	The child has witnessed verbal and/or physical domestic violence between the caregivers

age differences in the explaining factors, and to determine whether these factors should be included as covariates in the regression analyses. As age was divided into three groups, post hoc tests were conducted to examine which groups differed from each other. Subsequently, univariate logistic regression analyses were conducted to determine the relationship between each explaining variable separately (child factors: age, gender, behavioural problems, psychiatric problems, substance abuse, and MBID; parental factors: psychological problems, psychiatric problems, substance abuse, MBID, imprisonment, poor parenting skills, traumatic past, and divorce; and maltreatment factors: abuse/neglect, sexual abuse, and domestic violence) and each dependent variable (duration and success of FSO). Finally, the significant variables of these univariate analyses were included in two multivariate logistic regression analyses to examine the unique contribution of these variables to the explanation of duration and success of FSOs.

The assumptions of (1) a linear relationship between the continuous predictors and the logit of the outcome variable, and (2) whether the observations were independent of each other were tested (Field, 2009). Neither of these assumptions were violated. In addition to these assumptions, we also tested for multicollinearity with the Variance Inflation Factor (VIF). These results indicated no violations of this assumption.

## Results

### *Gender and age differences in study variables*

An overview of the percentages of the explaining factors and outcome variables, including their distribution by gender and age, tested by chi-square tests is presented in Table 1. It was found that girls were significantly more likely to be victims of sexual abuse than boys. In addition, it was found that boys were significantly more likely to have parent(s) who had been in prison than girls. It was also observed that adolescents were significantly more likely than children in early childhood to have behavioural problems, MBID, and to have been victim of sexual abuse. Furthermore, children in early childhood were significantly more likely than adolescents to have parents with MBID and parents with a traumatic past. Finally, adolescents were significantly more likely than children in middle childhood to have psychiatric problems, or parents who had been in prison.

### *Associations between child, parental and maltreatment factors and duration of FSO*

In order to identify which explaining factors were related to the duration of FSOs, first, univariate binary logistic regression analyses were performed for each explaining variable separately, while controlling for age and gender for the

outcome variables that showed significant differences in the Chi-square analyses results. The univariate results showed that the duration of the FSO was explained by the psychiatric problems and MBID of the child (see Tables 3 and 4). Children with psychiatric problems and/or children with MBID were more likely to have longer FSO trajectories than children without these factors. No parental or maltreatment factors were significantly related to the duration of FSO.

Subsequently, the significant variables were included in a multivariate logistic regression analysis to find out which variables had the strongest explaining value. At the first step of the multivariate logistic regression analysis, we included gender and age of the child. At the second step, the significantly explaining factors from the univariate analyses (child's psychiatric problems and child's MBID) were added. The second model was statistically significant,  $\chi^2$  ( $df = 2, N = 108$ ) = 14.01,  $p < .001$ , Cox and Snell  $R^2 = .17$ , Nagelkerke  $R^2 = .23$ . This means that the model in which the independent study variables (child's psychiatric problems and child's MBID), besides control variables (gender and age), were included, significantly explained the duration of an FSO. Coefficients for the model's independent variables are presented in Table 5. As can be seen in Table 5, both children's age and MBID significantly contributed to the explanation of the duration of FSOs. These results indicate that the odds of a longer FSO-duration were 7.41 times as large for younger children than for adolescents. Furthermore, the odds of a longer FSO-duration were 4.53

times as large for children with MBID than for children without MBID. Children's psychiatric problems did not appear to significantly explain the duration of FSOs in this multivariate analysis.

### Associations between child, parental and maltreatment factors and success of FSO

In order to identify which explaining factors were related to a successful FSO, comparable univariate binary logistic regression analyses were performed. The univariate results showed that the success of an FSO was explained by a child's MBID, sexual abuse victimization of the child, domestic violence victimization of the child, and parental divorce (see Tables 6 and 7). The statistics in Table 7 show that children with MBID and children who had been victim of sexual abuse had a lower chance of a successful FSO trajectory, and children who had witnessed domestic violence and parental divorce had a higher chance of a successful FSO trajectory than children without these factors.

Then, the significant variables were included in a final multivariate logistic regression analysis in order to identify which independent variables best explained the success of FSOs. At the first step of this multivariate logistic regression analysis, we included gender and age of the child. At the second step, the significantly explaining factors from the univariate analyses (child's MBID, sexual abuse, domestic violence, and divorce) were added. The second

**Table 3.** Associations between child, parental and maltreatment factors and the duration of FSOs ( $N = 138$ ).

	<i>N</i>	$\chi^2$ <sup>a</sup>	<i>p</i> -value	$R^2$ Cox & Snell	$R^2$ Nagelkerke
<b>Child factors</b>					
Early childhood	138	2.32	.128	.02	.02
Middle childhood	138	.03	.861	.00	.00
Adolescent	138	1.74	.187	.01	.02
Behavioural problems	120	1.54	.215	.05	.06
Psychiatric problems	108	4.04	.045	.07	.10
Substance abuse	68	.25	.620	.00	.01
Intellectual disability	138	12.97	<.001	.11	.14
<b>Parental factors</b>					
Mental health problems	138	1.48	.224	.01	.01
Psychiatric problems	138	.01	.928	.00	.00
Substance abuse	138	.00	.950	.00	.00
Intellectual disability	138	.06	.808	.02	.03
Imprisonment	138	2.25	.134	.04	.05
Poor parenting skills	138	.20	.658	.02	.03
Traumatic past	138	.13	.720	.02	.03
Divorce	138	.14	.707	.00	.00
<b>Maltreatment factors</b>					
Abuse and/or neglect	138	2.25	.134	.02	.02
Sexual abuse	138	3.60	.058	.06	.08
Domestic violence	138	.18	.670	.00	.00

<sup>a</sup> $df = 1$ .

**Table 4.** Coefficients and *p*-values of the significant (univariate) models for the explanation of the duration of FSOs.

Child factors	<i>B</i> ( <i>SE</i> )	<i>p</i> -value	Exp( <i>B</i> ) [95%CI]
<b>Psychiatric Problems</b>			
Constant	−.45 (.37)	.233	
Early childhood	1.46 (.66)	.026	4.30 [1.19, 15.52]
Middle childhood	.48 (.46)	.298	1.61 [.66, 3.97]
Psychiatric problems	.85 (.43)	.049	2.35 [1.00, 5.48]
<b>Intellectual disability</b>			
Constant	−1.20 (.48)	.012	
Early childhood	1.57 (.53)	.003	4.81 [1.70, 13.63]
Middle childhood	.54 (.47)	.248	1.72 [.69, 4.31]
Intellectual disability	1.53 (.46)	<.001	4.64 [1.89, 11.36]

**Table 5.** Coefficients and *p*-values of the significant (multivariate) models for the explanation of the duration of FSOs.

	<i>B</i> ( <i>SE</i> )	<i>p</i> -value	Exp( <i>B</i> ) [95% CI]
<b>Model 2</b>			
Constant	−1.79 (.60)	.003	.17
<b>Child factors</b>			
Early childhood	2.00 (.74)	.007	7.41 [1.73, 31.76]
Middle childhood	.76 (.50)	.130	2.14 [.80, 5.71]
Gender	.44 (.43)	.317	1.54 [.66, 3.62]
Psychiatric problems	.74 (.46)	.111	2.09 [.84, 5.19]
Intellectual disability	1.51 (.51)	.003	4.53 [1.68, 12.19]

Note. Model 2:  $R^2 = .617$  (Hosmer & Lemeshow), .17 (Cox and Snell), .23 (Nagelkerke).  
 Model ( $X^2$  (5) = 19.86,  $p = .001$ ).

model was statistically significant,  $\chi^2$  ( $df = 4$ ,  $N = 98$ ) = 23.92,  $p < .001$ , Cox and Snell  $R^2 = .25$ , Nagelkerke  $R^2 = .35$ . This means that the model in which the independent study variables (child’s MBID, sexual abuse, domestic violence, and divorce) were included besides the control variables gender and age, significantly explained the success of FSOs. Coefficients for the model’s independent variables are presented in Table 8. As can be seen in Table 8, children’s age, child’s MBID, sexual abuse, and domestic violence significantly explained the success of FSOs. These statistics also indicate that the odds of a successful FSO were 11.11 times as small for children in early childhood and 4.17 times as small for children in middle childhood than for adolescents. Furthermore, the odds of a successful FSO were 5 times as small for children with MBID, and 10 times as small for children who experienced sexual abuse than for children without these factors. Also, the odds of a successful FSO for children who had witnessed domestic violence were 4.44 times as large than the odds of a successful FSO for children who had not witnessed domestic violence. Gender, sexual abuse victimization and parental divorce did not appear to be significantly related to the success of an FSO in this multivariate analysis.

## Discussion

The objective of this exploratory casefile study was to examine whether child, parental and maltreatment factors were related to the duration and success of Family Supervision Orders (FSO) in families with MBID. First, this study revealed that in families with MBID, younger children, children with psychiatric problems, and children with mild to borderline intellectual disabilities (MBID) were relatively more likely to have longer FSO trajectories. Although psychiatric problems were not a unique explaining factor, it is still important to notice that they are associated with the duration of FSOs, and therefore a possible dynamic target for effective intervention to increase child safety. Second, it was found that in families with MBID, younger children, children with MBID and children who were sexually abused had relatively lower chances of successful FSOs. Finally, the results showed that adolescents, children who had witnessed domestic violence, and children whose parents were divorced were more likely to have successful FSOs. Even though the results were significant, it should be noted that the associations were small in magnitude.

Overall, the results of the current study show that only child factors explain the duration of FSOs, in that behavioural problems predict the duration of FSOs and MBID predicts both duration and success of FSOs. These findings are consistent with results previously reported by Glisson et al. (2000), who also found that child related factors (such as child’s disability) are related to a longer duration of state custody. It is not entirely surprising that these child factors are related to longer or unsuccessful FSOs, since raising children with special needs asks for additional requirements, especially for parents with MBIDs (Manders et al., 2009; McGaw et al., 2010). Children with MBID are more likely to have characteristics (e.g., emotional or behavioural problems) that may (further) contribute to abuse as well (Manders et al., 2009). Child-related issues are seen by most abusive parents as the source of the problem, because these issues cause stress to the parents. When the child is seen as the cause of the abuse there is no focus on the child as a victim and the abusive parent will reflect less on its own part and responsibility in the abuse, resulting in inadequate support and the continuation of the abuse. Finally, there is empirical evidence showing that children with MBID and/or behavioural problems generally need more care (e.g. McConnell et al., 2011b; 2011a; 2021), which may also contribute to longer involvement of child protection services to ensure the child’s safety.

Children in families with MBID having past or current experiences of sexual abuse were less likely to experience a successful FSO trajectory. Previous studies have found that the effects of sexual abuse tend to persist, and often lead to additional behavioural and psychological problems (Johnson, 2004; Kools & Kennedy, 2002). This places extra demands on the child-rearing capacities of the parents, it may require long term professional family support and intensive treatment

**Table 6.** Associations between child, parental and maltreatment factors and success of an FSO ( $N = 98$ ).

	$N$	$\chi^2$ <sup>a</sup>	$p$ -value	$R^2$ Cox & Snell	$R^2$ Nagelkerke
<i>Child factors</i>					
Early childhood	98	2.14	.143	.02	.03
Middle childhood	98	.08	.781	.00	.00
Adolescence	98	3.20	.074	.03	.05
Behavioural problems	81	1.31	.253	.07	.09
Psychiatric problems	71	.81	.367	.10	.13
Substance abuse	42	.19	.661	.01	.01
Intellectual disability	98	8.37	.004	.11	.16
<i>Parental factors</i>					
Mental health problems	98	.65	.420	.01	.01
Psychiatric problems	98	.55	.457	.01	.01
Substance abuse	98	.07	.786	.00	.00
Intellectual disability	98	.40	.526	.04	.06
Imprisonment	98	.82	.364	.01	.02
Poor parenting skills	98	.46	.497	.04	.06
Traumatic past	98	.17	.677	.04	.05
Divorce	98	4.22	.040	.04	.06
<i>Maltreatment</i>					
Abuse and/or neglect	98	.00	.952	.00	.00
Sexual abuse	98	9.06	.003	.12	.18
Domestic violence	98	5.53	.019	.06	.08

<sup>a</sup> $df = 1$ .**Table 7.** Coefficients and  $p$ -values of the significant (univariate) models for the explanation of the success of an FSO.

	$B$ (SE)	$p$ -value	Exp(B) [95%CI]
<i>Child factors</i>			
Intellectual Disability			
Constant	.95 (.61)	.117	
Early childhood	-1.95 (.69)	.005	.14 [.04, .55]
Middle childhood	-1.09 (.63)	.085	.34 [1.00, 1.16]
Intellectual disability	-1.59 (.59)	.007	.20 [.06, .65]
<i>Parental factors</i>			
Divorce			
Constant	-1.71 (.54)	.002	
Divorce	1.13 (.60)	.057	3.11 [.97, 10.01]
<i>Maltreatment factors</i>			
Sexual abuse			
Constant	.32 (.46)	.485	
Early childhood	-1.56 (.58)	.007	.21 [0.07, 0.66]
Middle childhood	-.99 (.61)	.107	.37 [1.11, 1.24]
Gender (female)	.01 (.48)	.992	1.01 [.39, 2.59]
Sexual abuse	-2.63 (1.12)	.019	.07 [.01, .65]
Domestic violence			
Constant	-1.95 (.62)	.002	
Domestic violence	1.39 (.66)	.036	4.02 [1.10, 14, 74]

of the children, who may have become traumatized, which eventually may result in a permanent measure (such as out-of-home-placement), and thus unsuccessful FSOs. Future research should examine whether these children received treatment for

their sexual abuse, which has been shown to be very effective for reducing both trauma symptoms and internalizing and externalizing problems (Hoogsteder et al., 2022; Somers et al., 2022). Moreover, Wissink and Moonen (2014) showed that



**Table 8.** Coefficients and *p*-values of the significant (multivariate) models for the explanation of the success of an FSO.

	B (SE)	<i>p</i> -value	Exp(B) [95% CI]
<b>Model 2</b>			
Constant	-.42	.651	
<i>Child factors</i>			
Early childhood	-2.39 (.78)	.002	.09 [.02, .42]
Middle childhood	-1.44 (.72)	.046	.24 [.06, .98]
Gender	-.26 (.55)	.634	.77 [.27, 2.24]
Intellectual disability	-1.60 (.66)	.015	.20 [.06, .73]
<i>Parental factors</i>			
Divorce	1.03 (.72)	.151	2.80 [.69, 11.43]
<i>Maltreatment factors</i>			
Sexual abuse	-2.36 (1.17)	.044	.10 [.10, .94]
Domestic violence	1.49 (.74)	.043	4.44 [1.05, 18.76]

Note. Model 2:  $R^2 = .762$  (Hosmer & Lemeshow), .25 (Cox and Snell), .35 (Nagelkerke). Model 2 ( $\chi^2 (7) = 27.83, p < .001$ ).

prevention of sexual abuse in children with MBID should focus on open communication about sexuality, alertness to behavioural signals and physical indicators of sexual abuse in children with MBID, and increasing knowledge among (helping) professionals about antecedents and signals of sexual abuse in children with MBID.

Sexual abuse of children in families with MBID primarily occurs outside the nuclear family, for instance, in the extended family, in school, in day care or residential institutions or in (day, weekend, school holiday or short/long-term) foster care (Wissink et al., 2015; Wissink & Moonen, 2014). Unfortunately, with the currently available data we were not able to distinguish between sexual abuse inside or outside the nuclear family. Therefore, future research should focus on finding out whether the outcomes of an FSO are different for children who have been sexually abused inside or outside the nuclear family.

An unexpected result was that children whose parents were divorced, and children who had witnessed domestic violence were more likely to have a successful FSO. This is in contrast to previous findings, which showed that domestic violence in families with parents with MBID did contribute to the decision to place children out-of-home (McConnell et al., 2011a). Domestic violence appears difficult to detect, because victims often isolate themselves. A possible explanation for our study findings is that once domestic violence has come to light, parents may choose to separate. This then may lead to a more stable home situation, allowing the focus to return to parenting, and thus to the child's safety, which is also an explanation for the result that children of divorced parents are more likely to have a successful FSO. McCarthy (2017) already concluded that family supervisors should be trained to recognize domestic violence so that it can be addressed. A possible explanation of the findings in this study is that when domestic violence is appropriately addressed, this is more likely to result in a successful FSO. This explanation should be examined in future research.

Besides parental divorce, parental factors were found not to be related to outcomes of FSOs. A first possible explanation is that in the current sample, parental factors did not show much variance. Second, parental factors comprised a rather broad category of factors (e.g., psychiatric problems include temporary depression as well as conduct disorder), while more meaningful analyses of more specific categories require larger sample sizes. Finally, in this study we examined which parental factors were present at the start of an FSO, but change over time in these factors (e.g., improvement in pedagogic skills, or decrease in mental health problems) might be more informative. Future research should explore whether these changes over time have an effect on the outcomes of FSOs.

In interpreting the results, several other limitations should be considered. First, the results were based on the information present in the casefiles, in which certain factors may not have been reported. Research from Gubbels et al. (2021) and Stams et al. (2010) indicated that safety and risk assessment instruments in child protection services are not always filled in correctly, causing underreporting or biased outcomes. Despite this limitation of casefile research, this method of data collection is the least intrusive for clients, as well as the most cost-effective way to gain important insights in the benefit of the mandated care provided by child protection services (Zegers & Wollersheim, 2012).

Additionally, the statistical power of the logistic regression analyses was somewhat compromised in the sense that effects had to be small-to-medium in order to become significant. Furthermore, we conducted 15 univariate analyses, which increases the risk of finding significant results solely by chance. However, Streiner and Norman (2011) argued that (explorative) hypotheses that are derived from literature decrease the risk of chance capitalization, making correction for multiple testing less necessary or even undesirable. Nevertheless, given the number of tests and correlational nature of our study its significant results should be interpreted with caution, in particular if they are unexpected. They need replication in future research.

Also, the operationalizations of both duration and success of FSO have limitations. The aim of an FSO is that parents are able to regain full responsibility for their child (ren) within an 'acceptable' time period. However, the duration of what is considered to be 'acceptable' is not fixed. This makes it difficult to determine a standard cut-off score. In this study, a period longer than 2 years was considered to be a long FSO, based on research by Slot et al. (2001), which indicated that most concerns about the child's safety tend to decrease in the first 2 years of an FSO. More importantly, an FSO is not intended to be a long term solution, and more severe child safety problems require a different, permanent measure.

Despite these shortcomings, the current study is, to our knowledge, the first to examine child, parental and maltreatment factors as explaining factors of the duration and success of FSOs. Moreover, this study is the first to focus specifically on families with MBID. The complexity of problems and overrepresentation of families with MBID in

child protection systems underline the importance of this study.

The authors recommend that in future research the ways in which parental factors influence the outcomes of an FSO should be explored more in detail. Also, as mentioned above, understanding the treatment/care factors during an FSO are important to examine in order to establish whether these factors affect FSO outcomes. In addition, future research will need to examine the extent to which multiple risks contribute to FSO outcomes, given the likelihood of (child and parental) problems co-occurring, especially for families with MBID who often experience a cumulation of problems (Meppelder et al., 2015; Wilson et al., 2013). Finally, longitudinal studies are needed to obtain more reliable data on which risk and protective factors in families with MBID are longitudinally related to the outcomes of an FSO. Hereby, it is recommended to intensively follow families receiving care for longer periods of time through, for example, home observations and questionnaires.

The results of this study add to the knowledge on families that are overrepresented in child protection. Our study distinguished between child, parental and maltreatment factors to explain the duration and success of FSOs in families with MBID. Only child factors predicted duration of FSO trajectories, while children's MBID, sexual abuse, parental divorce, and domestic violence predicted success of FSO trajectories. When the family supervisors are aware of these risk factors that may lead to long and/or unsuccessful trajectories, specialized care that is responsive to the specific needs of families with MBID can be provided. An early and successful completion of the FSO might be achieved when responsive interventions are used, which target the specific problems, such as those associated with MBID in children or trauma caused by sexual abuse. The knowledge provided by this study and suggestion for future research that follow from these findings are considered as first steps in improving the effectiveness of child protection measures for families with MBID.

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### Ethics Approval

The study procedure was approved by the Ethics Review Board of the University of Amsterdam (case number: 2019-CDE-10,129).

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