

Transforming Child Welfare Systems
to a 21st Century Model
that Strengthens and Supports
Families and Communities:
Innovations from the Field



Alliance
*for Strong Families
and Communities*®



Within Our Reach

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Introduction

In 1995, the U.S. Advisory Board on Child Abuse and Neglect issued its report “A Nation’s Shame: Fatal Child Abuse and Neglect in the United States.” The report highlighted the concern that every aspect of the child protection system was in such a state of crisis that the safety of children could not be assured. The Advisory Board found that because of the sheer number of child maltreatment cases, reduced resources, increasing complexities in family structures, and the collapse of social support mechanisms, little could be done within the existing system to keep kids safe. Thus, rather than attempting to revamp a failed institution, the Advisory Board called for a new, universal system grounded in communities.

Twenty-five years later, the federally-appointed Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) recommended the same in its framework for the elimination of child abuse and neglect fatalities. In its final report, the Commission stated that: “A set of recommendations that aims simply to improve the current system of child protection in this country may reduce the number of fatalities, but we have reached the conclusion that eliminating these deaths altogether requires fundamental reform. That’s why our national strategy proposes a new and reinvigorated child welfare system for the 21st century.... To build a 21st century child welfare system, we need a comprehensive public health approach premised on the importance of strong, integrated, and collective responsibility and coordinated action and measurement across agencies and states and within our communities. A public health approach for child safety is one that promotes the healthy development and well-being of children. It builds off a public health model used to tackle complex social problems, a model with a focus on prevention and support for community change.”

To promote the CECANF recommendations and the need for child welfare reform, the Within Our Reach office was established within the Alliance for Strong Families and Communities in 2016. Within Our Reach plays a coordinating role as a central point of contact and resource center in this national effort, which works to achieve its goals through a spirit of shared ownership among many partners. The goal of Within Our Reach is to equip policymakers, practitioners, and advocates with the tools they need to transform child welfare into 21st century child and family well-being systems that focus on preventing child abuse and neglect and strengthening families.

To ensure that another 25 years does not pass before significant transformation does occur, national, state and local leaders are engaged in numerous efforts to promote, guide and implement change. Jerry Milner, associate commissioner of the US Administration on Children, Youth and Families (ACYF), began his tenure in 2017 stating that: “We (ACYF) are very interested in changing our current system so that it strengthens the resiliency of families as our primary intervention and gives children what they need to thrive ... First, we need to change the focus of child welfare to primary prevention of maltreatment and unnecessary removal of children from their families. We can only break the cycle of family disruption and maltreatment by addressing the root causes of those situations ... Right now we typically respond only after families have lost much of their protective capacity and children have been harmed. We need to strive to create environments where they get the support they need before harm occurs, which in my mind is a reconceptualization of the mission and functioning of the child welfare system.”¹

In its 2019 annual report, Casey Family Programs (CFP) states that: “Today the child welfare system in America is entering a watershed period. With greater knowledge about what works best to keep children safe, strengthen families and address the lifelong impact of trauma, leaders in government, business, nonprofits, philanthropy and communities are thinking, planning and acting in ways that can help transform our approach to child protection into a true system of child and family well-being.”

With that goal in mind, CFP, in partnership with ACYF, the Centers for Disease Control (CDC), the Association for State and Territorial Health Officials (ASTHO) and American Public Human Services Association (APHSA) organized three convenings in 2018-2019 of transformational leaders across the child welfare ecosystem to activate the building of a 21st Century child welfare system. These sessions were designed to commit participants to a common vision, improve understanding of a public health approach to child welfare and begin the steps needed

1 Trump’s Top Child Welfare Official Speaks. Chronicle of Social Change. November 6, 2017. Interview with Daniel Heimpel. <https://chronicleofsocialchange.org/featured/trumps-top-child-welfare-official-speaks/28583>

to support this change effort. CFP also has a national steering committee that is developing a framework to guide change.

This document is designed to describe a public health approach and provide some examples of innovations states and communities are implementing in their efforts to become a 21st century model of child welfare, many of them based on the recommendations of CECANF and the frameworks being developed through the CFP convenings.

Part One: A 21st Century, Public Health Approach

Child maltreatment usually occurs in the context of multiple stressors that take a toll on children, families, communities and also on agency systems and staff. A public health approach recognizes and works to reduce these stressors to strengthen the network of support for families. Successful transformation of child welfare systems to a public health model should include the following goals:

- Children are not injured nor do they die from abuse or neglect.
- Children are valued, loved, and cared for first and foremost by their parents.
- The safety and well-being of children are everyone's highest priority, and federal, state, and local agencies work collaboratively with families and communities to protect children from harm.
- Leaders of child protective services (CPS) agencies do not stand alone but share, with multiple partners, a responsibility to keep children safe long before families reach a crisis.
- Research and integrated data are shared in real time in order to identify children most at risk for abuse or neglect fatalities and help providers make informed and effective decisions about policies, practices, and resources.
- State and local agencies charged with child safety have the resources, leaders, staff, funds, technology, effective strategies, and flexibility to support families when and how it is most helpful.
- Every child has a permanent and loving family, and young parents who grew up in foster care get the support they need to break the cycle of abuse and neglect.
- All children are equally protected and their families equally supported, regardless of race, ethnicity, income, or where they live.

The current child welfare system is vastly different than one based on strengthening families and communities. Commissioner Milner described our current system as one that:

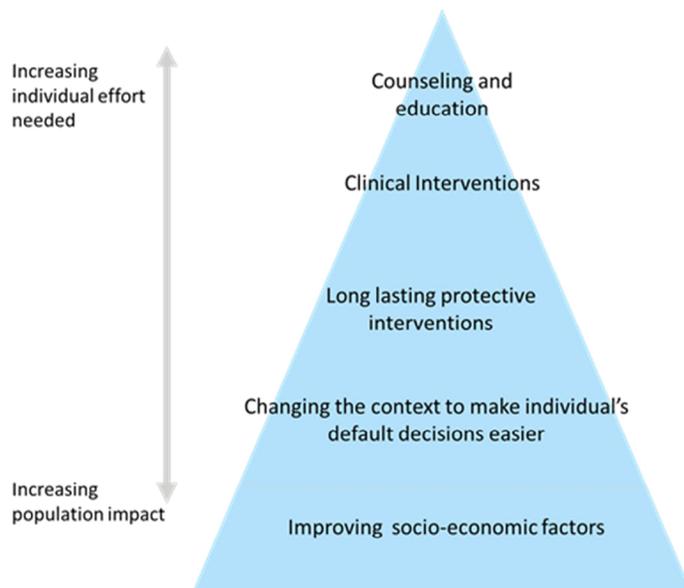
- Is reactive to concerns about harm already done to children with a focus on investigation, treatment, and compliance with mandated services.
- Often approaches caregivers with punishment versus support and has an emphasis on child protection over child welfare or prevention.
- Is focused on individuals rather than populations.
- Subjects persons involved in the system, including children, caregivers and agency staff, to the trauma of the consequences of harmful behaviors and potential or real removal of children from families.
- Places less emphasis on the prevention of harm and more on protection from harm.
- Features systems overburdened with limited resources to fully support staff, foster families, relative caregivers, children and those aging out of the foster care system.
- Often responds to critical incidents by blaming agencies and their staff for failing to protect children which often leads to removals of more children from their families.

Transforming child welfare to be more focused on supporting families does not mean that we abdicate our responsibilities to keep children safe. There are many ways we can improve child protection work concomitant with a public health approach. The Commission to Eliminate Child Abuse and Neglect Fatalities recommended that we improve child safety by screening in all infants, improving coordinated child safety investigations, making improvements to the work force (especially reducing caseworker workloads), conducting case reviews of deaths and serious incidents of maltreatment to identify systems problems; improving our ability to recognize injuries as maltreatment, sharing data on high risk families across systems including with law enforcement, and improving standards for mandatory reporters. However even with these changes, shifting our focus to supporting families will ultimately mean that fewer children will need protecting because their families are better supported, safe and healthy.

A public health approach supports the notion that population problems require population-based solutions. It is based on the belief that interventions designed to improve health and safety are most effective when they reach broad segments of society, require less focus on individual interventions and address socio-economic determinants of health and safety before harm occurs. It also is based on the fact that individual interventions and treatment can be costlier, even if effective, and reach far fewer people than interventions that work to address the underlying causes of the problem in the first place. Public health interventions can be delivered at greater scale to communities, reach into risk groups requiring more focused interventions but still link services to persons in need of additional support. The public health pyramid reflects this:

Historically, public health and child welfare/social services were not distinct entities. The early social reform movements in the U.S. led to major improvements in population health, child safety and protection. For example, disease prevention resulted more from improvements in sewer lines and indoor plumbing than from vaccinations; child labor laws improved child safety, and requirements on work hours and wages improved family well-being. It wasn't until the federal government began separating funding streams for services in the 1930s that the two fields diverged. Even public health moved a bit away from its focus on social reforms, adopting an emphasis on a more bio-medical model of infection control. But today public health is once again focusing on improvements to inequities and social determinants of health.

To put it simply, a perfect public health approach would focus on preventing adverse childhood experiences, intercepting trauma before it strikes and strengthening communities and families in universal ways. A public health approach to child maltreatment would incorporate many core public health frameworks and processes. These include:



Adapted from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/>

A Health Equity Framework: understanding and working to eliminate historical, systemic inequalities that lead to poor outcomes for families and working for the fair, just distribution of the social resources and social opportunities needed to achieve well-being.

Health Equity work addresses and changes the underlying social inequalities that are the root of health inequalities rather than only the consequences (social determinants). To apply a health equity framework means understanding how communities came to be and working to fundamentally change the balance of power. Communities that are known to be at highest risk for unhealthy outcomes often bear witness to the constellation of power differentials and the resulting public and private beliefs, actions and policy decisions that have been made over decades, usually on the basis of race and geography. And yet, it's not only place and race that impact inequalities but other human characteristics such as class, gender and sexual orientation that can influence and compound these persistent and systemic inequalities.

A very current example of systemic inequity has emerged in the wake of the COVID-19 pandemic. As the disease has progressed across community after community, it has put a spotlight on the longstanding and glaring inequities in our current health care system that target communities of color -- inequities that our nation has failed to confront or address for far too long. This impact is being felt among communities of color and families with low-income who are disproportionately black, latinx, and native American. APM Research Lab recently released a September 2020 report showing that Black Americans are dying from COVID-19 at a rate three times that of whites. More than 20,000 African Americans have died of COVID-19 to date, a number that is .05 percent of the

African American population. As of September 15, 2020, 1 in 1,020 Black Americans has died (or 97.9 deaths per 100,000). Some states are seeing even larger disparities, including Kansas, where blacks are dying at a rate seven times that of whites; Michigan and Missouri, where deaths among blacks are five times that of whites; and New York, Louisiana and Illinois, where the death rate is three times that of whites. In a statement, U.S. Surgeon General Jerome Adams acknowledged the challenges of growing up in poorer communities of color, stating “the chronic burden of medical ills is likely to make people of color especially less resilient to the ravages of COVID-19.”

Another example of systemic inequity is the practice of red-lining neighborhoods. In 1935, the U.S. Federal Home Loan Bank authorized the Homeowners Loan Corporation to create “residential security maps” in 239 cities. These maps were lines of different colors around neighborhoods that graded them as prospects for investment. A green line meant a neighborhood was the best for home loan investment, blue was “still desirable”, yellow was “definitely declining” and a red line meant the neighborhood was “hazardous.” Communities red-lined were suddenly not only kept out of home mortgage investments but other investments stayed away as well: industry, commerce, human services, etc. Not surprisingly, red-lined neighborhoods tended to be already poor, black or newly immigrant. Although red-lining practices were outlawed in the 1970s, today one can overlay current socio-economic status data over red-lined communities and see that poverty, crime, food deserts, poor educational outcomes, and poor health indicators mimic the boundaries of the red-lines. This systemic, political, institutionalized system of economic racism worked its magic in keeping people in these neighborhoods at a disadvantage to the more affluent white persons in the other “more desirably-graded” communities.

Yet another example is the persistent disparity in infant mortality between black and white babies. Black infants in the U.S. are twice as likely to die before the age of one than white babies -- a disparity that is wider now than it was 15 years before the end of slavery. This gap adds up to almost 4,000 lost black babies a year. While the exact cause is unknown, it is known that a black woman with a college degree is more likely than a white woman with less than a high school education to suffer an infant loss. It is believed that the stress of being a black woman in America, with the inescapable atmosphere of societal and systemic racism, creates a toxic physiological stress resulting in conditions such as hypertension and pre-eclampsia -- leading directly to higher rates of infant death. This toxic stress coupled with well-known and documented racial bias in health care treatment of black women (including the dismissal of legitimate worries during pregnancy) is believed to be behind the mystery of the disparity.

A Social Determinants of Health Framework: understanding and working to eliminate conditions that put some people at higher risk for poor life outcomes.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the systemic health inequities affecting the distribution of money, power and resources described in the previous section. Many models of social determinants are included in socio-environmental frameworks. There are literally dozens of illustrative models that describe the interrelationship of individuals, family, community and society to social and environmental factors that affect health and well-being over the life span.



There are many social determinants including the following:²

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Social support	Provider availability
Expenses	Safety	Vocational Trng	Affordability	Community engagement	Provider cultural competency
Debt	Parks	Higher education		Discrimination	Quality of Care
Medical Bills	Playgrounds	School quality		Stress	
Support	Walkability				
	Zip Code				

There is no consensus on the magnitude of contributions of each of these to maltreatment but there is a growing body of literature that demonstrates that social determinants have an impact on maltreatment. It is widely accepted that poor social conditions strongly correlate with higher rates of maltreatment, including concentrated poverty, unemployment, high population density, poor housing, lack of childcare options, low educational achievement, social isolation and community violence. For example, a review of the literature found economically distressed and overcrowded communities are risk factors for maltreatment.³ Another demonstrated a relationship between increased abusive head trauma (AHT) and areas experiencing economic recessions: AHT significantly increased from 8.9/100,000 to 14.7 more than five years into the recent recession in a 74-county region.⁴ A 2019 report from the American Public Human Services Association (APHSA) and Mathematica found that young children of mothers with non-standard or changing work schedules are at greater risk for health and behavior problems, increasing their risks for maltreatment as well.⁵

Addressing social determinants means addressing poverty. Perhaps the most startling statistic related to maltreatment is from the third National Incidence Study on Child Maltreatment that found that parents with incomes less than \$15,000 are 22 times more likely to abuse or neglect their children than persons with incomes above \$30,000. While poverty may be the single best predictor of maltreatment, there are many complex variables that impact and confound the relationship between poverty and maltreatment rates. These include evidence that poor families are more likely to be subjected to more investigations and substantiations of maltreatment and parent factors such as education, employment, housing instability, neighborhood and family size. The Center for Disease Control's (CDC) Technical Package for Preventing Child Abuse and Neglect recommends a number of evidence-based interventions focused not on the typical approach, such as modifying caregiver behavior, but on strengthening economic supports for families.⁶ Examples presented include:

- Improving child support: A study of mothers receiving TANF benefits compared those receiving the full amount of child support from the non-custodial parent to mothers who received the greater amount of \$50 or 41 percent of the child support paid by the non-custodial parent. Children of mothers in the intervention group were 10 percent less likely to have a report of child abuse or neglect that was investigated by child protective services.

2 Artiga, S and Hinton, E. Beyond Health Care: The role of social determinants in promoting health and health Equity. May 2018 Issue Brief. Kaiser Family Foundation. San Francisco. <http://files.kff.org/attachment/issue-brief-beyond-health-care>.

3 Coulton, C.J., Crampton, D.S., Irwin, M., Spilsbury, J.C., & Korbin, J.E. (2007). How neighborhoods influence child maltreatment: A review of the literature and alternative pathways. *Child Abuse and Neglect*, 31, 1117-1142.

4 Berger, R.P., Fromkin, J.B., Stutz, H., Makoroff, K., Scribano, P.V., Feldman, K., Li, C.T., & Fabio, A. (2011). Abusive head trauma during a time of unemployment: A multicenter analysis. *Journal of the American Academy of Pediatrics*, 128(4), 637-644.

5 Rachidi, A, Sykes, R, Desjardins, K, Chaidez, C. (May 2019) The New Economy and Child Care: Nonstandard-hour work, child care, and child health and wellbeing. APHSA and Mathematica. Washington, DC. <https://files.constantcontact.com/391325ca001/fe2f3845-da8f-46be-a3a9-aeb94fbdef5f.pdf>

6 Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

- Provision of food supports: a study linking administrative databases found that among children enrolled in Medicaid, families receiving SNAP or receiving nutrition benefits through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) had fewer reports of abuse and neglect than families not receiving SNAP or WIC.
- Paid family leave: studies found that paid leave is significantly associated with reductions in hospitalizations for abusive head trauma and paid sick days and paid vacation were found to be also associated with lower rates of depression and stress, both of which are risk factors for child abuse and neglect.

Applying a Life Course Perspective: understanding and applying the impact of adverse childhood and life experiences and supporting improvements across the life span from pre-conception through to older adulthood.

The life course trajectory views “health not as disconnected stages (infancy, early childhood, adolescence, child-bearing years, and old age) unrelated to each other, but as an integrated continuum. This perspective suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person’s life.”⁷ It has become widely accepted that the “toxic stress” of maltreatment leads to poor outcomes lasting into adulthood. There is a large body of literature cutting across many different domains that demonstrate these outcomes. The Adverse Childhood Experiences (ACE) study singularly spawned numerous other studies pointing to poor medical and public health outcomes related to early adversities.⁸ These outcomes include mental health problems such as depression; difficulties sustaining intimate relationships; substance abuse and suicide; interfamilial violence throughout life; academic difficulties and failures; early initiation to sexual activity, delinquency, and crime; and increased risk for several chronic diseases.

We know that child maltreatment and exposure to impersonal violence make children susceptible to recurrent forms of victimization over their life course. This life course perspective of violence has demonstrated that perpetrators were often themselves abused, and their perpetration of abuse continues a cycle of violence that is difficult to stop. One study assessed the risk for maltreatment by mothers experiencing intimate partner violence (IPV).⁹ Both IPV and maternal parenting stress were found to be indicators for maltreatment, suggesting that IPV and maltreatment prevention and intervention efforts should be better integrated to meet the needs of both mothers and their children.

The Use of Data: leveraging information to better count maltreatment, understand risk and protective factors, the best places to focus interventions and to evaluate effectiveness.

A public health approach should rely heavily on socio-demographic data to:

1. Accurately count child maltreatment in populations.
2. Describe and understand risk and protective factors for maltreatment.
3. Identify hot spots for interventions to deliver services and programs where most needed.
4. Understand the underlying impact of interventions and evaluate effectiveness.

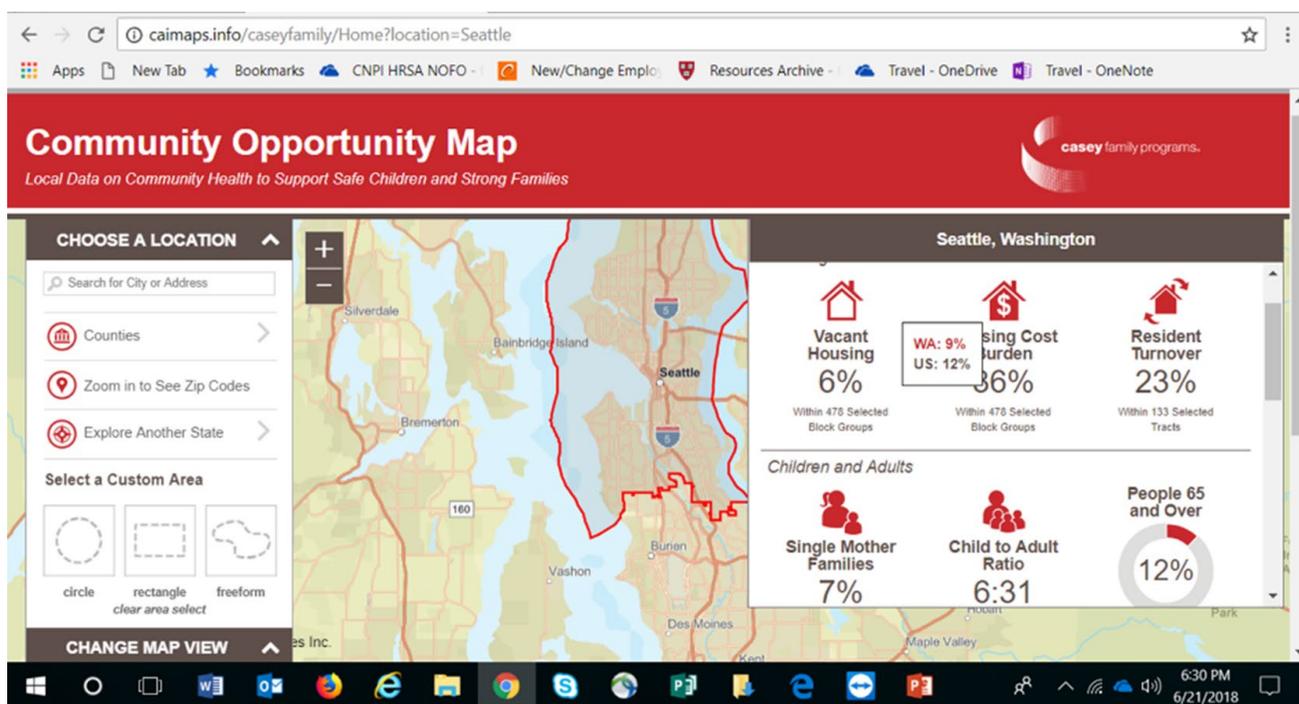
7 Pies, C., Lu, M., Kotelchuck, M., & Parthasarathy, P. (APHA 2008). Creating a Paradigm Shift in Maternal and Child Health: Advancing the Life Course Perspective. 136th American Public Health Association Annual Meeting and Exposition. October 25, 2008

8 Felitti, V.J., Anda, R.F, Nordenberg, D., Williamson, D.F., Alison, M.S., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *Journal of Family and Consumer Services*, 14(4), 31.

9 Taylor, C.A., Guterman, N.B., & Lee, S. (2009). Intimate partner violence, maternal stress, nativity, and risk for maternal maltreatment of young children. *American Journal of Public Health*, 99(1), 175-183.

A public health approach to maltreatment means counting more than the number of children entering into child protection, but includes analysis looking at root causes and systemic factors, including policies, practices, and decision-making norms that result in greater risk of maltreatment, inequitable treatment, disparities, and disproportionality. These analyses can help in identifying where to focus interventions. For example, an innovative study found that children reported for non-fatal maltreatment had a heightened risk of unintentional and intentional injury before the age of five; and found that children with prior allegations of maltreatment died from intentional injuries at a rate 5.9 times greater than children with no reports.¹⁰ An earlier study of maltreatment fatalities found that low-income children who had experienced a first incident of maltreatment had almost twice the risk of dying from preventable causes including accidents and recurring maltreatment than other low-income children not experiencing maltreatment, leading to the conclusion that, “A public health approach to improve early childhood parenting or access to dependable childcare for families who do not qualify for more intensive services may be beneficial.”¹¹

Geospatial mapping is being used more widely as a public health data approach to understanding and responding to maltreatment. Casey Family Programs has developed [Community Opportunity Maps](#) which map out and highlight social determinants associated with child maltreatment. The tool included community indicators composed of select U.S. Census Bureau indicators at geographic levels defined by the user, from the state level down to neighborhoods. Predict-Align-Prevent, a Texas based nonprofit organization, is also using geospatial data along with intensive community engagement to develop prevention interventions in a number of communities. An example of their work can be found in the [technical report](#) they completed for Virginia’s Department of Social Services in 2019.



Predictive Analytics is a relatively new data tool for human services being used to better understand and respond to maltreatment. It applies algorithms based on a number of complex data points to understand which children are at highest risk and then develops interventions to respond. There are a number of different models in play across the U.S

10 Putnam-Hornstein, E. (2011). Report of maltreatment as a risk factor for injury death: A prospective birth cohort study. *Child Maltreatment*, 16(3), 163-174.

11 Jonson-Reid, M., Chance, T., & Drake, B. (2007). Risk of death among children reported for nonfatal maltreatment. *Child Maltreatment*, 12, 86-95.

Coordinating, Collaborating and Integrating Efforts Across Systems: assuming that child maltreatment will never be prevented until agencies begin working across sectors and accept that maltreatment is a community problem.

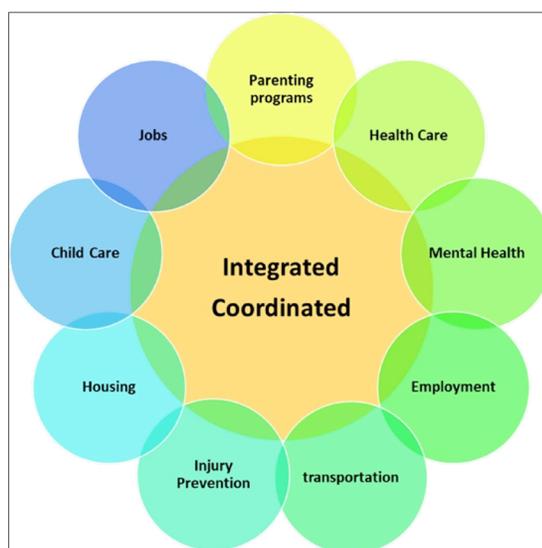
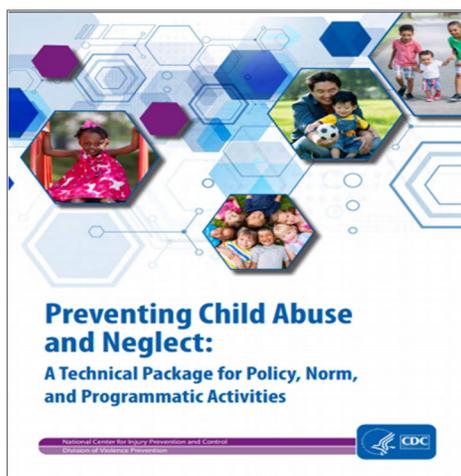
It means that there is no tolerance for not working together. Child protection agencies cannot be viewed as being the only agency responsible for both child safety and prevention. The Commission to Eliminate Child Abuse and Neglect Fatalities' national strategy included that, "A public health approach to child safety engages a broad spectrum of community agencies and systems to identify, test, and evaluate strategies to prevent harm to children ... we need a system that does not rely on CPS agencies alone to keep all children safe. We must effectively marshal the knowledge, skills, and resources of all government and community agencies that come into contact with families and children. We need public will, shared accountability, local and state and federal leadership, and partnerships with the private sector to bring solutions to life."

Bringing multiple partners together also requires a shift in perspective outside of child welfare. For example, a 2009 survey of state public health agencies' involvement and support of child maltreatment prevention efforts found that 82 percent considered child maltreatment to be very important to the agency and 69 percent agreed that CM is a public health issue. Despite these high percentages, only 35 percent had a designated state staff person in their public health agency responsible for child maltreatment prevention.

Working across systems also means including the voice of families and persons with lived experiences. This requires agencies to recognize families and others as experts, to value their knowledge and opinions and to proactively and consistently encourage and empower them to participate in all stages of planning, implementing and evaluating interventions.

Focusing on Prevention through Evidence-Based Promising or Effective Interventions: investing in primary and secondary interventions and intervening early and comprehensively to strengthen families and communities and reduce risk factors.

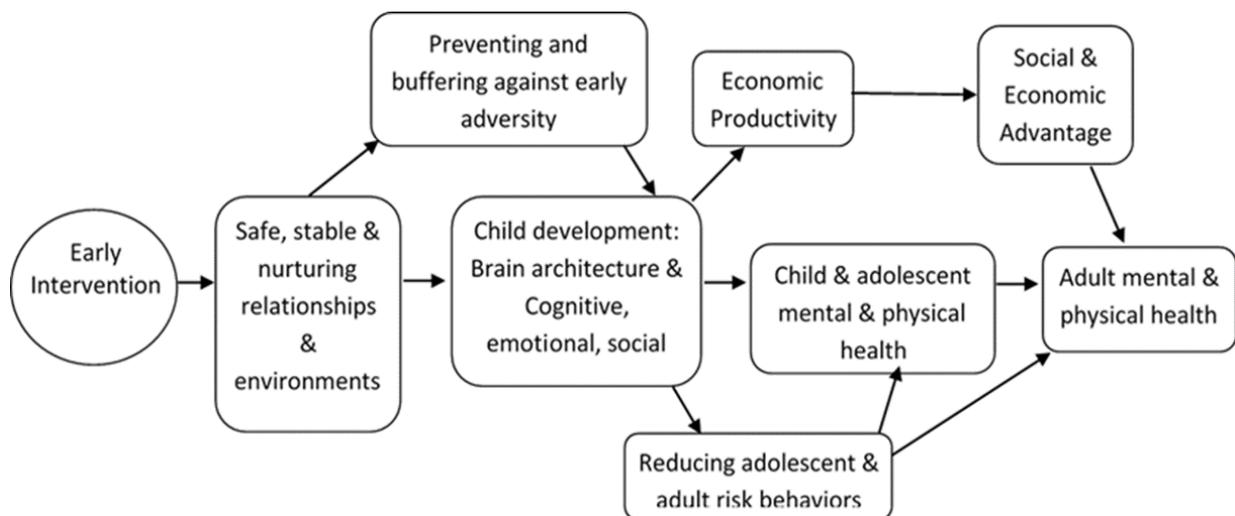
A hallmark of the public health approach is promoting interventions that have been tested for effectiveness. Public health interventions can be universal or targeted to children most at risk. Using an understanding of social determinants of health and child maltreatment data, a public health approach to interventions is comprehensive, focused on multiple layers and ultimately supportive of the development of safe, stable and nurturing relationships. The CDC's Technical Package for the Prevention of Child Abuse and Neglect recommends that a public health approach includes integrated, coordinated interventions targeting the social determinants of health to have the greatest impact.



Interventions recommended in the package include:

- Strengthen economic supports for families: Child support payments, tax credits, SNAP flexibility, housing mobility, subsidized childcare, living wages, paid leave, predictable work schedules.
- Change social norms to support parents and positive parenting: Public engagement and education campaigns, laws to reduce corporal punishment.
- Enhance parenting skills to promote child development: Home visitation, parenting skills and family relationship approaches.
- Promote Early childhood care and education: Preschool enrichment with strong family engagement, childcare licensing and accreditation.
- Include Secondary prevention: Interventions to lessen harm, enhanced primary health care, behavioral parent training, therapeutic treatments that are trauma informed.

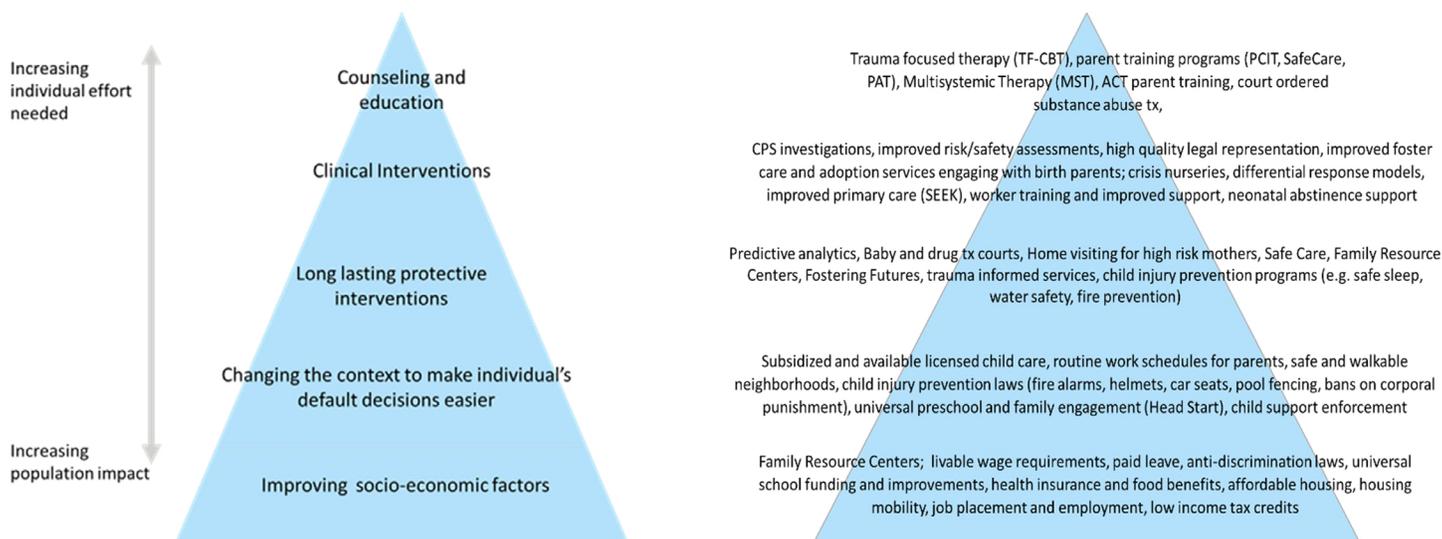
A public health approach also focuses interventions as early as possible. The CDC presented a model demonstrating that early intervention impacts short and long-term wellbeing outcomes¹²:



12 Centers for Disease Control and Prevention. (2012). Tools and strategies to support health departments in child maltreatment prevention efforts webinar. Retrieved from <http://www.childrensafetynetwork.org/webinar/cdc-webinar-tools-and-strategies-support-health-departments-child-maltreatment-prevention>

In Summary

Applying a public health approach to transforming child welfare will promote the healthy development and well-being of children and their families while at the same time keeping children safe. Applying the public health pyramid to child welfare illustrates that it is possible to maintain child safety while at the same time working to eliminate the disparities and social determinants that lead to child maltreatment.



Child Safety Suggested Interventions

Adapted from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/>

The gravitational pull for many in child welfare is still child protection. Until we make a commitment to begin moving towards family support and early intervention, we will never have a chance to lessen that pull. The Casey Family Programs convening on the 21st Century approach to child welfare resulted in this vision:¹³

“We seek to transform into a family well-being system that prevents child harm by working in partnership with children, families, communities, and agencies, to assure all families have the capacity to care for their children, and all children thrive in safe, stable, nurturing families and environments.”

Part Two: Examples of State and Community Efforts

Following are examples of the work already underway that demonstrates this transformation is possible. Information presented was taken through interviews, site visits, presentations at the Casey Family Programs convenings, and information taken verbatim from individual program web pages. There are of course a multitude of programs and services throughout the U.S. that already do much to build strong families and communities. These examples were chosen because they represent places that started in one direction and made conscious choices to transform their work towards a more family-supportive, public health approach to child welfare. All of the examples incorporated more than one of the public health principles described in part one. There are also other examples highlighted on the Within Our Reach and Casey Family Programs websites. All of those and the ones presented here are now actively engaged in identifying and responding to the root causes of child abuse and neglect, rather than waiting until children are no longer safe and in need of removal from their own families. Within Our Reach welcomes learning about other examples of work, which can be shared with us at withinourreachemail@alliance1.org.

New York City, NY: Challenging the Status Quo to Keep Families Out of Child Welfare

David Hansell, the Commissioner of New York City's Administration for Children's Services, is providing leadership to create an ecosystem that takes a public health approach to child welfare with a heightened emphasis on prevention. In a series of webinars about their work, he says: "We have tried to create a knowledge-based culture that infuses a common theoretical framework into the work of multiple systems and providers that interface with families." Commissioner Hansell has stated that:

1. We want to start with what we know works, what we know achieves demonstrable results.
2. We don't want to focus on preventing repeat maltreatment, we want to focus on preventing maltreatment altogether.
3. We want an entire ecosystem of services and partners dedicated to these goals including parents – rather than a child protection agency struggling to achieve them in isolation.
4. We want child welfare organizations to be learning organizations, not invested in the status quo. And we want to create a culture in which the response to making mistakes, which are inevitable, is to learn from them to make the organization stronger, rather than assigning culpability.
5. We want to be part of the effort to heal inequity, which is based primarily on race and secondarily on poverty, gender, sexual identity, etc. We want to be part of the solution, not part of the problem.

Under his leadership, NYC conducted a top to bottom review of all initiatives, services, policies, and child welfare data. A report from this review has led to realms of activity. NYC is committed to:

1. Using evidence-based and evidence-informed programs in all their preventive services and programs.
2. Using predictive analytic models for collaborative safety science approaches to spur systemic safety improvements in child welfare.
3. Seeking collaborative partnerships with providers to implement prevention programs and continuous quality improvement.
4. Changing its focus on outcomes from recidivism in child welfare to overall child and family well-being and poverty reduction. This includes development of a new diversion program to avoid court-ordered supervision that gives families specialized services.

To identify the highest risk cases, they implemented a quality assurance process to ensure that investigations are being done in a way that is consistent with practice. This included:

- Identifying lower risk cases where families have successfully engaged in services so that they can close their case and make that preventive slot available to another family in need.

- Ensuring consultants with subject matter expertise, for example, in substance abuse or mental health, are being utilized when they are most needed so that staff can leverage their expertise.

A hallmark vision of Commissioner Hansell's was to prevent involvement with child welfare for high risk families and instead work to provide them with support. The Division of Child and Family Well-Being was established with core components:

1. Early Learn, a center-based early childhood care and education program, including Early Head Start and Head Start.
2. Universal free, high-quality preschool for every four-year-old, which will be expanded to all three-year-old children in the city over the next three years.
3. Hubs for community resources in 11 high-needs communities, through community partnership programs. Those hubs help "connect the dots" between services.
4. Three Family Enrichment Zones and Centers, which are currently being piloted in the Bronx and in Brooklyn. These Centers were co-created with families in the communities, based on the needs that they identified for their respective community. The Centers are intended to build connections, so they have an open-door policy and families are not required to register for services or to be connected to any other ACS services.

In January 2020, Commissioner Hansell announced the new prevention portfolio for the city. It provides funding to a full range of supportive services for families in all five boroughs and all communities across New York City. The new programs build upon ACS's existing prevention services system and represents the first complete restructuring of that system in a decade. The new system will have:

- Universal service access: For the first time, all prevention models will serve every borough and every neighborhood, so that services are more accessible to families that need them, and the city can better match families to appropriate services regardless of where they live.
- Family choice: The new program models will require providers to incorporate family voice and choice, to ensure that prevention services reflect what families want and need, and to improve parental engagement.
- More therapeutic and treatment services: The new system will expand New York City's investment in evidence-based models. And for the first time, therapeutic and treatment models will make up most of prevention slots.

The Hansell administration is also highly committed to equity work and has developed an equity action plan.

One result of the long-term focus on prevention in New York City is a significant decline in the number of kids in foster care: In 2018, fewer than 1.5 percent of families that completed prevention services had a child who was later removed and placed in foster care. Today, there are fewer than 8,500 children in foster care in New York City – down from nearly 50,000 in the 1990s and more than 16,000 just a decade ago. There are also fewer youth in juvenile justice detention.

San Francisco, CA: Family Resource Centers Moving Prevention Upstream with Strong Community Collaboration

Family Resource Centers (FRCs) are community-based resource hubs where families can access formal and informal supports to promote their health and well-being. FRCs can be in apartment complexes, schools, health centers, libraries, community centers, storefronts, or churches. FRC services also vary widely but typically include some combination of the following: parent skill training, job training, substance abuse prevention, mental health services, housing support, crisis intervention services, literacy programs, and concrete supports such as food or clothing banks.

[The National Family Support Network](#) (NFSN) is a membership-based organization comprised of statewide networks of two or more Family Support and Strengthening programs, such as Family Resource Centers. There is no dedicated federal funding for FRCs, and yet there are more than 3,000 of them nationwide.

In San Francisco, three public agencies – Health and Human Services; First Five; and the Department of Children, Youth, and Families – have blended funding to support a network of 26 FRCs across the city/county. The FRCs focus on family engagement by meeting the immediate needs of the family, as defined by the family, and then conducting an assessment that becomes the basis for a plan of additional services and supports. FRCs offer three different levels of intervention: basic, comprehensive, and intensive. Intensive services include CPS services, such as supervised visitation. The location of these services was determined with the help of zip code analysis, so that services could be easily accessible to families in need. Except for CPS court-ordered services, all other FRC services are voluntary.

Safe and Sound, an FRC in San Francisco, has an on-site center and works with parents to ensure they have the knowledge, resiliency, basic resources, and connections they need to have a strong and healthy home. It also works with children to ensure they have the skills they need to identify and express their emotions, and appropriately interact with other children. Its coordinated system of care builds on the strengths of a family and supports them with educational workshop, community events, dinners, support and play groups, parenting classes, counseling, and basic needs like groceries and bus tokens.

Safe and Sound also developed a report detailing the costs of child abuse to the State of California as well as to the greater Bay Area and San Francisco County. One year of child abuse costs the state 19.3 billion dollars.

San Francisco has seen a significant decline in the number of confirmed cases of child abuse and neglect, as well as in the number of children in care. It is believed that these improved outcomes are due in part to the prevention services offered through the network of FRCs; in part to changes in CPS practice, including the implementation of differential response, Structured Decision-Making, and Signs of Safety; and in part to the changing demographics of the city/county, as the cost of housing has driven many families with children to move out of the area.

Casey Family Programs Resource Pages has an [issue brief](#) describing in detail the characteristics of FRCs and a [snapshot of the research](#) demonstrating the success of FRCs centers in reducing risks of maltreatment and entry into foster care.

Source: Sylvia DePorto, Consultant/Formerly the Director of Family and Children's Services for San Francisco, and Katie Albright, CEO, Safe & Sound and their websites)

Arizona: Safe Babies Court Team - From Cradle to Crayons

Baby courts are designed to bring a multi-agency team together to identify, plan and manage services for parents with a goal of avoiding removals and keeping kids in home. First developed by the national organization, Zero to Three, the Safe Babies Court Team™ approach transforms child welfare into the practice of child “well-being” by using the science of early childhood development. The program connects babies and their families with the support and services they need to promote healthy child development, while at the same time ensuring speedier exits from the system.

Through community-wide collaboration led by the judges who oversee child maltreatment cases, children 0-3 and their families are receiving focused attention that recognizes individual strengths and challenges. Interventions are offered to meet the specific needs of each child and parent. Unlike typical foster care cases where formal hearings occur every 3 to 6 months, these families and the teams of professionals hold hearings and/or family team meetings at least once a month. The teams that work with the judges are cross-trained in infant mental health, substance abuse, therapeutic treatment approaches, etc.

This approach is recognized by the California Evidence-Based Clearinghouse for Child Welfare as being highly relevant to the child welfare system and demonstrating promising research evidence. National results show that children in baby courts are reaching permanency three times faster than infants and toddlers in the general foster care population. Almost two-thirds of them find permanent homes with members of their families while only one-third of infants and toddlers in the general population exit foster care to family members.

Services could include substance abuse treatment, housing, job placement, adult education, and in-home treatment. Some courts also work to provide tangible resources to families such as baby supplies, laundry detergent, diapers, etc.

Maricopa County, the fourth largest county and court system in the country, implemented the best practices of Zero to Three’s Safe Babies Court team model starting in 2011. Implementation required the Court to convene traditional and new partners, to obtain new funding commitments, to address concerns from the bar regarding new communication paths, and to share data with the university for evaluation. Taking the model to scale required some creativity in addressing the key components. A multi-year evaluation is demonstrating that the approach has decreased the time to permanency and the rate of re-entry after reunification for our youngest children.

Zero to Three has developed a Guide to Implementing the Safe Babies Court Team Approach.

Source: Judge Colleen McNally (retired) and Zero to Three website

Milwaukee, WI: Housing Opportunities Made to Enhance Stability (HOMES)

A stable, healthy, and affordable home provides a foundation for well-being and prosperity for children, families and communities. Stable housing can positively affect many social determinants for children and families, including academic performance, physical, and mental health. Families that struggle to achieve or maintain housing stability are at elevated risk for a wide range of poor outcomes, including child abuse and neglect. Evidence suggests that providing assistance with housing and other concrete needs (e.g., clothing; furniture) may reduce the risk of abuse and neglect. Along with its threats to child safety, poor housing jeopardizes family preservation and child permanency goals. Among families that are referred to child protective services, those with a history of housing instability and homelessness are at a greater risk of having a child removed from their care. Housing problems can present barriers to family reunification as well. In sum, inadequate housing may contribute to entering the child welfare system and difficulty exiting the system. Disentangling the risk factors for child maltreatment and housing instability, such as crowding, eviction, and homelessness, is difficult and requires a multi-system approach.

The Housing Opportunities Made to Enhance Stability (HOMES) initiative began when Children's Hospital Community Health Navigators and Well-Being Assessment programs both identified housing as a needed resource and driver of well-being outcomes in the populations they served. HOMES is focused on developing partnerships across health, child welfare, housing, and other systems to integrate and streamline services and policies to support stable housing for families facing complex challenges.

HOMES used a public health approach to data to better understand the problem in Milwaukee. They found that 81 percent of parents cited housing instability prior to children entering foster care. For families in the child welfare system, especially those with children placed in out-of-home care, problems with poverty and insecure housing are particularly acute. A study found that in Milwaukee, compared to families receiving voluntary in-home services, families with a child in out-of-home care were almost twice as likely to have been evicted and almost three times as likely to have been homeless in the prior year. Supporting these findings, data collected by Children's Hospital of Wisconsin demonstrate that children who are placed in foster care in Milwaukee often come from families who have a history of overcrowding, eviction, and homelessness.

HOMES engaged the community through community cafes, surveys, and other resident participation, to establish partnerships across health care, child welfare, housing, and other systems. The HOMES team is using this feedback with research and other evidence to advance program changes at Children's and broader policy solutions that support stable housing for families. This includes ensuring that housing needs are included and case management works to improve housing options for families at intake, assessment and service planning.

Milwaukee, WI: SaintA - Moving Away from Foster Care Services to Early Intervention Services

SaintA began in Milwaukee in the 1850s as two separate orphanages. As children's needs evolved over the years, orphanage life was replaced by foster care and therapy services. Today SaintA is a non-sectarian nonprofit facilitating equity, learning, healing and wellness by providing family support services that restore the connections that help children and families thrive.

In addition to its core child welfare services, it has a new endeavor that aims to keep families out of the child welfare system completely. The Early Intervention Services (EIS) program, a subset of the agency's Intensive In-Home Program, is a short-term intervention that connects families with long-term supports. EIS case managers work with Initial Assessment (IA), the government entity that receives and analyzes reports of child maltreatment.

Under state child welfare laws, IA has 60 days to investigate and decide what happens next. EIS is all about moving things along much quicker. If there is immediate danger, IA creates a protective plan. An EIS plan must be finished within two weeks from the initial EIS referral date.

EIS was created through a collaboration among SaintA, Children's Hospital of Wisconsin Community Services, and the Division of Milwaukee Child Protective Services. SaintA and Children's are the two agencies contracted to provide child welfare services in Milwaukee County.

The EIS program aims to address underlying issues and safety concerns. "This is an innovative way to preserve families and prevent children from having to enter the child welfare system," said Lisa Vega, SaintA's child welfare program director. And the effort is unique among Wisconsin's 72 counties, she said.

SaintA Intensive In Home program is very different from the way things are done in the other 71 counties in the state, Lisa said. "And based on our experience, we want to figure out the best way to help these families and keep them in their homes."

In addition to moving things along sooner, the goals of EIS are to collect information about a family's functioning and dynamics and to prevent child welfare involvement completely after a case is closed.

"EIS is very proactive vs. reactive," said Rosemary Brunner, child welfare supervisor. "It's about addressing issues before things have the potential to get much worse."

Services based on safety concerns include food, clothing, housing, instruction on how to manage a household, day care and respite assistance, and help for children with special needs. Interventions that are more change-oriented include household support such as obtaining car seats and safety gates; in-home health care referrals; mental health, alcohol, and drug abuse referrals; parenting education; social support and recreational activities; transportation assistance; and therapy and counseling.

"There are a lot of resources available in the county, but people just don't know about them, or they don't know how to navigate the systems," Brunner said.

Case managers interact with clients multiple times a week, with a goal of "getting in and out as quickly as we can," she said.

"The biggest issue is housing," Brunner said. SaintA collects its own resources and helps people get on waiting lists for low-income housing. Case managers also help with transportation and filling out paperwork.

"A lot of it is simply pointing people in the right direction," Brunner said. "It's not that these are bad parents, they just get into bad situations."

Source: *SaintA website*

Colorado: Maltreatment Prevention Framework for Action

When the Family First Prevention Services Act was passed in 2018, one of its requirements is that states take steps to study fatalities and develop a maltreatment fatality prevention plan. It turns out that the state of Colorado has a strong history of supporting child injury prevention and fatality review. The state's Child Death Review Program is a comprehensive system of fatality prevention. The state also is far along the path to implementing a fatality maltreatment prevention plan that is incorporated into their broader child maltreatment prevention plan and activities.

The Colorado Department of Human Services (CDHS), Office of Early Childhood, in partnership with Chapin Hall at the University of Chicago, designed the Colorado Child Maltreatment Prevention Framework for Action as a tool to guide strategic thinking at the state and local level about resource investments to prevent child maltreatment and promote child well-being.

The foundational principles represent a strong public health approach to prevention and include: monitoring program implementation, strengthening the work force, fostering data integration, incentivizing continuous quality improvement, honoring family and participant voices and driving policy integration. Anchored by these foundational principles, the framework outlines potential strategies that when implemented will achieve four overarching outcomes to ensure that all children are valued, healthy and thriving. These outcomes include: child wellbeing and achievement, consistent high-quality caregiving, caregiver wellbeing and achievement, and safe and supportive neighborhoods.

The Framework for Action is a toolkit that communities can use to study data, develop plans, obtain funding and implement their prevention strategies. It includes suggested strategies at multiple levels including individual services such as home visiting, agency collaboration and community capacity building, organizational and practice change and policy reform.

Through funding from the CDHS Office of Early Childhood and the ZOMA Foundation, fifteen communities were able to create local child maltreatment prevention plans. Five more communities were selected to begin creating local child maltreatment prevention plans in 2019.

The effort has led to a set of [Child Maltreatment Prevention Framework Tools](#) that communities can use to study, plan, implement and evaluate their work.

Monterey County, CA: Road Map to Child Well-Being

Monterey County, California is a complex community divided by the “salt line.” Affluent communities live west of the line along the Pacific Ocean and a high number of poor families live east of the line, working mostly in the agricultural industry. Many families are undocumented workers. In 2015, the county had two tragic murders of children from abuse and a third child suffered severe physical abuse. All had involvement with child welfare. The Director of Human Services (since retired), Elliott Robinson, realized that, “In the immediate aftermath of a child death, such as the one mentioned, it is expected that the child welfare agency conducts a critical incident review and takes every appropriate action to improve its processes; but, those inwardly focused system improvement efforts alone are not enough. Child abuse and neglect occurs in the context of a host of stressors that take a toll on child and family well-being: overcrowded housing, poverty, community violence, and unstable employment opportunities. These stressors also take a toll on public systems committed to improving community quality of life -- human services, health, law enforcement, and education. A more meaningful system improvement process recognizes this broader context and works toward strengthening the overall public and community-based network that needs to work together for child safety and well-being.”

He knew these deaths would trigger calls for more removals into foster care. But he decided to take a different approach: move forward with a coordinated community-wide improvement of systems -- not more removals.

He reached out to funders and community change agents. Within Our Reach at the Alliance for Strong Families and Communities and The American Public Human Services Association supported the effort with consultants to help frame and staff the planning efforts. Director Robinson formed an executive advisory team, a project team and three task forces: community engagement, collaborative service delivery and data and information-gathering. He convened a number of community conversations and a community-wide assessment that led to a large-scale planning effort to create a mosaic of services and prevention efforts. Training was provided to leaders and community members from the Frameworks Institute on the best way to frame the issues. All this work became the Monterey County Road Map to Child Well-being.

The road map includes many outcomes and initiatives to promote healthy families for all people in all places in the county. They include:

1. Enhancement of the current system by designing services and resources that are available within the community for prevention measures.
 - a. Establishing a nurse-family partnership program.
 - b. Strengthening knowledge of child abuse and neglect reporting through training in multiple sites throughout the county.
 - c. Supporting a community of collaborators and develop principles for leaders.
2. Enhancement of the current 211 system in designing services and resources that are available within the community for prevention.
 - a. Development and marketing of community asset maps.
 - b. Development of information hubs for the community. Ensuring that spaces and places for community engagement are available throughout the county.
3. Improvement of community understanding of child abuse prevention and interventions and the understanding of what constitutes abuse or neglect.
4. Development of a community of caring adults involved in children’s lives.
5. Sharing information with diverse populations including the undocumented and indigenous communities.
6. Development of community-based systems which support families to build their own self-sufficiency and competencies.

7. Provision of preventive and early intervention programming as joint ownership.
 - a. The first effort in the community is development of a community navigator program, which places navigators at places in the community visited by families who may need assistance finding the right mix of services and programs for their needs. The navigators will break down barriers for families needing help, understand sources of power in the community, understand agencies' processes, help families find answers and get services, and relentlessly not take no for an answer in helping families.
8. Information sharing is clearly defined, meets confidentiality and privacy requirements and is integrated into training and practice.
9. Integration of case management that is clearly articulated by leadership and embedded in operations, procedures, training and practice.
10. Business practices are designed to treat clients holistically so that they receive the maximum services allowable.
11. Legal and policy processes are clearly defined and maintain respect of customer's privacy.
12. Regular feedback is sought in a systematic way from users that identifies service delivery strengths, gaps and solutions and is incorporated into activities that improve outcomes.

Texas: The Division of Prevention and Early Intervention Program

The Texas Department of Family and Protective Services (DFPS) created a division solely devoted to addressing risk factors that lead to abuse and neglect. Rather than waiting for a child to be harmed before intervening, the Division of [Prevention and Early Intervention \(PEI\)](#) applies a public health approach to keeping children safe: providing population-based services to all families; normalizing a parent's need to seek help; and instilling a collective sense of responsibility for the safety and well-being of all children.

Casey Family Programs highlighted PEI in full as a resource on their website. [Read the full description.](#)

Allegheny County, PA: Building Bridges

Much has been written, talked about, and debated about Allegheny County's use of predictive analytics to inform child welfare services. What is not as well-known are the other changes the county has made to be more about supporting families and less about removing children from their parents. Three areas provide excellent examples.

The first is the use of integrated data. Allegheny County found a way to develop one unified human service data base over 23 years ago. It includes person-level data from systems throughout the county, including schools, social services, health, mental health, etc. It is universal --meaning any county resident is included in the system, not just persons obtaining public services. Data can be shared across agencies for planning and the provision of services. The system is considered a community asset.

The second is the development of 28 family resource centers (FRCs) throughout the county -- available to any resident family.

Third is the high level of systems integration and interagency coordination and collaboration. Pittsburgh is known as the city with the most bridges in the world. The Department of Human Services (DHS) has followed suit by building arguably the most bridges of any human service agency in the country. DHS has a Director of Integrative Programs whose job is to ensure high quality integration across multiple layers of services and programs and to identify barriers to service integration. There are six Children and Youth Offices throughout the county. Every office includes not just child welfare/child protection workers but the space is shared with addiction counselors, mental health specialists, housing counselors, on-site nurses from the children's hospital, shared intimate partner violence counselors and staff, father engagement specialists, education advocates, food and nutrition support staff and food pantries, youth support workers (almost all alumni), home visiting services and 'Parents as Teachers' staff. The county also works to integrate home visiting with the family resource centers and Head Start.

Marc Cherna, the innovative leader and director of Human Services said that "the 21st Century approach means that human services should be a positive part of the community and work across sectors because all of us should be a part of helping families." Director Cherna makes it his mission to build positive relationships and pitch positive stories about the families his agency serves. He described a number of ways DHS is out front in a positive way. Examples include pitching positive stories; fundraising for innovative DHS community activities including the DHS music festival and the Money Tree (to help kids in care enjoy activities not normally available to them such as music lessons and trips); sponsoring comedy nights, holiday projects, project prom; and more.

Brooklyn, NY: Center for Family Life in Sunset Park

Sunset Park is a densely populated, low-income neighborhood in Brooklyn, New York, with a large percentage of recent immigrants. Community residents have limited access to the resources needed to grow and thrive. Within this context, the Center for Family Life (CFL) in Sunset Park offers a comprehensive range of programs and services that address families' needs from every angle. These include family counseling and neighborhood-based foster care; cultural, educational and recreational programs at neighborhood public schools; adult and youth employment programs; and an emergency storefront for food and advocacy.

Their "secret sauce" is their ladder of leadership. Many of the current leaders at the center were part of center services in kindergarten. The Center has supported these leaders through college and even some in masters' programs.

One of the unique features of their service portfolio is [neighborhood based foster care](#). "By placing children with foster families in the community, the program seeks to reduce the trauma of separation from family members and to maximize opportunities for remediation and reunification in a normalizing neighborhood environment. Our program model is based on providing help to overcome barriers to effective parenting and supports to promote greater parental competency. Equally important is our focus on supporting meaningful community involvement in networks of friends and social services, with the goal of promoting ongoing family stability. Birth parents, foster parents, and children have access to services and resources at the Center and in the community, both during and after the placement period."

CFL also recognizes that strong and healthy families need economic stability. CFL has a summer jobs program for youth and provides economic literacy for families including help with banking, credit card debt, job placement, and small business development. The CFL Cooperative Development Program (CDP) organizes community members to create worker-owned cooperative businesses with the mission of economic and social justice. Since 2006, CDP has incubated and supported more than 15 cooperative businesses, including Si Se Puede/We Can Do It cleaning, Beyond Care childcare, Golden Steps elder care, Émigré Gourmet catering, Trusty Amigos dog walking and pet care, Maharlika office cleaning, Sunset Scholars tutoring, and NannyBee childcare.

Their new Sanctuary Families Project helps support undocumented parents who worry about the potential of arrest and deportation. The Center helps these parents designate guardians, prepare legal documents and make other preparations. The center is also training strangers to be sanctuary families in the event of sudden separation.

Virginia: Improving Child Safety and Reducing Child Fatalities

Carl Ayers, the former director of Virginia's Division of Family Services within the Department of Social Services, participated in the state's program reviewing child deaths in Virginia. Over 90 percent of the deaths reviewed were believed to be preventable with an appropriate response. He was seeing far too many of Virginia's babies die from unsafe sleep situations, the leading cause of non-natural deaths of infants in Virginia. Many of the families experiencing loss were low-income families receiving various services from the Department of Human Services (DHS). As Carl put it, "I'm not going to have another day of four babies dying from unsafe sleep under my watch." He also knew he couldn't prevent these deaths through the lens of CPS, "it was much too late for an intervention at this time."

Virginia was one of the states participating in the Three Branch Institute focused on child fatality prevention. Using data and geospatial mapping, Virginia worked to identify the communities and key social determinants underlying these infant deaths.

As a result, the state launched the Baby Box Partnership to distribute a baby box to every newborn family in the state. Families receive the box in the second trimester of pregnancy after watching a 15-minute safe sleep video. The box can be used as a place for safe infant sleep and comes with information on safe sleep practices. The state also launched a website on safe sleep and a strong safe sleep social media effort.

Although the program originated out of the state's child welfare office, family do not see the service as a CPS-funded and supported initiative. The initiative is also serving as a good entry point for nurses to provide home-visiting services.

At the same time, Carl's team began work with the City of Richmond to geomap risk and protective factors for child abuse. The maps led to further analysis to align and monitor resources, strategies for community engagement, services, assets and gaps in services and programs. The state eventually engaged with Predict-Align-Prevent to develop an open source geospatial machine learning approach to model the risk of child maltreatment in the City of Richmond. Predict-Align-Prevent is a nonprofit that provides technical assistance to communities to utilize geospatial data along with intensive community engagement to develop prevention interventions in a number of communities. The conclusions drawn from the [report](#) include:

"In the PREDICT phase, we found the places where children are at greatest risk of maltreatment, ranking the most important risk features by correlation to child maltreatment events. The majority of child removals and child maltreatment fatalities occurred in the predicted highest risk locations.

During the ALIGN phase, we identified the existing community voice, potential protective assets, potential community "champions" for prevention work, coalitions and service providers working on problems with similar risk factors and target populations, specific crime-attracting infrastructure, and psychographics for optimal community engagement.

Remaining data needs for analysis include the x-y coordinates for specified death types so that cross-sector stakeholders can visualize how their ACEs-related areas of focus co-occur in the same places, and are inextricably linked to child abuse and neglect. This is a critical step for cross-sector engagement for strategic planning."

The next step will be to work with cross-sector stakeholders to apply this intelligence to tactical action for the prevention of child maltreatment. The focus of strategic planning for prevention includes:

- Collaboration among coalitions working to prevent problems with similar risk factors and target populations (minimize duplicative or conflicting efforts, maximize shared resources).
- Executive leadership and policies in support of evidence-based and evidence-informed practices.
- A cross-sector customer experience design which engages and sustains community relationships.
- Longitudinal population-level health and safety metrics for evaluation of the effectiveness of aligned resources.
- Objectively effective prevention programs and services.
- Prevention funding to meet capacity needs for effective service.

Birth and Foster Parent Partnership: Striving for Reunification not Termination

The Birth and Foster Parent Partnership (BFPP) was formed in 2016 to support birth parents, foster families and kinship care providers in building connections and using their voices to transform systems, policies and practices to improve permanency outcomes for children and families. The partnership is being managed through a collaboration between the Children's Trust Fund Alliance, Youth Law Center Quality Parenting Initiative and Casey Family Programs (CFP).

The concept is to elevate the voice of all persons in the system, reducing trauma for children and families, and ultimately working towards reunification. A foundational principle is that healthy, loving relationships are the number one priority and should inform all child welfare decisions, with a focus on strengthening families and avoiding removals. As a collective group, the partnership is working together to accomplish the following goals:

Increase involvement of birth parents, foster parent and kinship care providers in advocacy for improved policies and practices that benefit families and children.

Identify strategies to help birth parents and foster parents work together to keep children safe at home whenever possible and to facilitate reunification and prevent re-entry when foster care is necessary.

Increase capacity of child welfare systems to recruit and retain foster parents willing and able to partner with birth parents.

A number of the recommendations that the partnership of birth and foster parents are already being implemented in communities throughout the US. They include:

Building successful interactions between foster parents and birth parents and creating opportunities for sharing information and discussing the needs of the child(ren) for which they both have mutual concerns.

Encouraging birth and foster parents to participate together in their children's medical appointments and school conferences.

Recruiting foster parents who are eager and willing to work with and mentor birth parents.

Developing and implementing foster parent trainings that can include strategies and skill building exercises to support working effectively with birth parents, including ensuring birth parents help train foster parents.

Developing and implementing trainings for social workers and other professionals that support foster parents in partnering with birth parents and dispel fears and misconceptions about connecting with them.

Encouraging child welfare agencies to create policies that support effective partnership practices, including sharing information and reviewing guidelines for confidentiality.

Encouraging child welfare staff to help birth parents and foster parents access community supports, including activities they can do together (e.g., parenting classes, family field trips at family centers, etc.).

Promoting training and practices that support birth parents, foster parents, kinship care providers and staff in becoming experts in building their protective factors and supporting each other in those efforts.

The Partnership promotes a number of different avenues for disseminating their approaches. The Youth Law Center's Quality Parenting Initiative (QPI) was launched in 2008 in Florida, and as of 2018, over 75 jurisdictions in 10 states (California, Florida, Illinois, Louisiana, Minnesota, Nevada, Ohio, Pennsylvania, Texas and Wisconsin) have adopted the QPI approach. One component of QPI is having birth parents, foster parents, kinship caregivers and former and current foster youth as equal partners with agency staff, community partners and other child welfare stakeholders. QPI steering committees, which include birth parents, foster parents, kinship care providers and foster youth, meet regularly to identify barriers to quality parenting and to implement solutions to those barriers. The voices of parents, caregivers and youth are vital for this planning and implementation process. This type of

structure helps break down communication barriers and promote information-sharing and teamwork in developing policies and practices that will support strong partnerships. For more information about QPI, visit <http://www.qpi4kids.org>.

Another format is the Community Café that can be used to engage foster parents, kinship care providers, birth parents and other key stakeholders in shorter-term or specific issue-focused strategies using a strengths-based approach.

[Resources on the Partnership at Casey](#) tells the story of a birth and foster parents: how they met, forged a relationship and now are working together in Sonoma County, California to improve outcomes for both parents and their children. CFP's report also states that, "More and more child welfare agencies are using Parent Partner Programs to help build relationships, communication and understanding among staff, foster parents and birth parents when the family first enters the system. Parent partner programs engage as staff parents with prior experience in the child welfare system and they may be called parent allies, veterans, mentors, advocates, or other similar titles. The goals of parent partner programs may vary, but are typically to engage parents more fully in the child welfare case planning and services process; provide information to parents about the child welfare system and their rights and responsibilities and provide support, modeling, and linkages to assist families in meeting their safety, permanency and wellbeing goals."

The partnership is in the process of developing tools, e.g. a co-parenting pact template, to help support agencies that want to further partnership efforts.

One of the challenges of the partnership concept is the reaction from those that are parenting to adopt, with their concerns about losing their foster children back to birth families before their adoptions go into effect. However, as one birth parent stated at the 2019 CFP meeting of the Partnership, "My prayer is no more division. I want love, lightness and respect... We start from a position of love. Every child deserves to keep everyone in their life that they love."

Tucson, AZ: Casa de los Ninos – From Congregate Care to Child Care

Forty-five years ago, Casa de los Ninos began as a crisis nursery in a small house. It was a place for children to stay in order to give parents a short break. No one using the nursery had involvement with child welfare. Over the years it evolved to become a traditional residential center for foster children.

In 2004, leadership began a comprehensive evaluation of their place in the child welfare continuum. They re-envisioned the agency as a family-centered, place-based support center for families. They expanded home visiting, built a network of foster care homes, and were still housing children in their residential center.

Then the Board decided to do a deep dive and try to find out what would support families even earlier and have a greater long-term impact in the community. They wanted to get in front of prevention and expand the supports they were providing to families.

The Board chose to completely change Casa de los Ninos – it closed its door to residential care and reopened them as an early child care center. They now accept a mix of low-income and high-income families, accept children who have trouble staying enrolled in other centers for behavioral reasons, and include children with child welfare involvement and foster children. They still continue their nurse-family partnership program, parents as teachers, licensed foster care homes, in-home services and behavioral health.

Closing the residential center was a painful process, especially for the staff and volunteers. As the CEO Susie Huhn stated, “Many of our volunteers came because they loved rocking the babies. Many felt that they lost their identity and purpose with our new center.”

The new center leadership believes its new approach will yield positive outcomes and be a great investment for families, for example, in school readiness and success.

Susie Huhn talks about the transformation as a very painful process but one that she believes is worth it. She states that she would do it all over again.

Other Promising Efforts

There are numerous other efforts across the U.S. that when taken together demonstrate significant movement towards the transformation of child welfare into a 21st Century system.

Providence, RI: In Providence, Rhode Island, child welfare has worked with local police to embed police with social workers when they make home visits on referrals to CPS. Both CPS and the police are trained to make these visits with a trauma-informed lens. Another innovation in Providence is the Walking School Bus Program launched by Family Service of Rhode Island, a nonprofit, social service organization. Trying to address high rates of truancy and chronic absenteeism among kindergarten children, it was first thought that parents were being neglectful. After a study of Medicaid and other data, it became more apparent that truancy was not a “parent problem” but one of perceived safety. Parents were keeping their children home because they did not feel it was safe for them to get to school on their own. Other safety reasons were involved as well. The Walking School Bus provides volunteers to walk students to and from schools at multiple locations throughout Providence. The program is going strong, with over 13 partners. In the first year of the program, 79 percent of the students showed improvements in attendance.

Cleveland, OH: In 1852, Beech Brook opened its doors as the Cleveland Orphan Asylum for 50 children. It evolved into a campus of residential treatment cottages for emotionally disturbed children and included residential and day treatment. In 2016, Beech Brook closed the residential treatment section and today focuses on providing an expanded array of services ranging from prevention, education, early intervention and mental health treatment in community-based settings. The hub of their child abuse prevention work is their Family Center which provides a comprehensive set of services and programs for families.

New Jersey’s Department of Children and Families achieved a 45 percent reduction in the use of congregate care from 2009 to 2016. The system of care approach, made available to all families regardless of geography, income, or child welfare involvement, provides children and families with the services they need and helps prevent children from entering care as a result of behavioral health crises. When placement into care is necessary, investing in a rich menu of support for resource families (kinship, foster, adoptive) is key to reducing reliance on congregate care and improving timeliness to permanency. Positioning care management organizations to monitor, advocate, and support the youth and family during residential treatment, and to help families prepare for the child’s transition home, is important. Casey Family Programs describes the approach in detail in [their resources section](#).

Predict-Align-Prevent is currently working with several communities across the U.S. to use open-sourced geospatial mapping, community engagement and strategic planning to better understand, predict and respond to child fatalities and child abuse. The areas working with PAP include Arkansas, New Jersey (Camden and Cumberland County), Washington, DC, Oregon (Portland and Bend), New Hampshire (Manchester and Coos County), and Virginia (Richmond).

Two efforts that are working to advance equity include Pasco County, Florida’s Early Childhood Court Team and the Ramsey County, Minnesota Child Protection Services Division. In Pasco County, a multi-disciplinary team made a shared commitment to advancing equity, shared together their challenges in engaging with families based on identity and race, and used experts to obtain training on race, culture and ethnicity. The training helped the team understand how to integrate equity concepts into their own work. In Ramsey County, the Anti-Racism Initiative engaged agency and community stakeholders to analyze service data to select two areas of concern: disproportionate screen-ins and placements of children of color. The group is moving ahead to continue examining how equity and bias impacts policies and programs within the child welfare community.

Using Fatality Data to Drive Change in Sacramento and Baltimore: Two communities on opposite ends of the U.S. mainland conduct high quality fatality reviews in a multi-disciplinary team setting. The Sacramento County Child Death Review (CDR) team compiled and analyzed data from 20 years, as well as other demographic and geomapping data. In stark relief was the finding that African American children in Sacramento died at rates twice that of white children and were more likely to be involved with government “relief” programs. The county partnered with the Sacramento County Blue Ribbon Commission on Racial disparity to act on these findings and have begun implementing services in specific neighborhoods focused on improving child maltreatment and

youth violence outcomes for children. In Baltimore City, the child death review team conducted in-depth reviews of child maltreatment deaths. Like Sacramento, the data pointed to a number of significant findings including: victims were predominantly infants and toddlers who go unidentified by the system; caregivers were struggling with substance use, mental health disorders, intimate partner violence, their own histories of abuse and neglect, and the challenges of poverty, including lack of safe child care; early childhood prevention services were not reaching many of the families who may need them most; better collaboration could yield rewards for service and investigative agencies aiming to prevent fatalities; and Baltimore City's health care system represented tremendous opportunity for prevention and intervention. Recommendations that are still in the process of being implemented include differential response for toddlers and infants, better identification of risks within the health care community, better access to substance abuse treatment, more safe and affordable child care and care coordination for families with histories of abuse and neglect.