CHAPIN HALL
AT THE UNIVERSITY OF CHICAGO

Meeting Family Needs

A multi-system policy framework for child and family well-being

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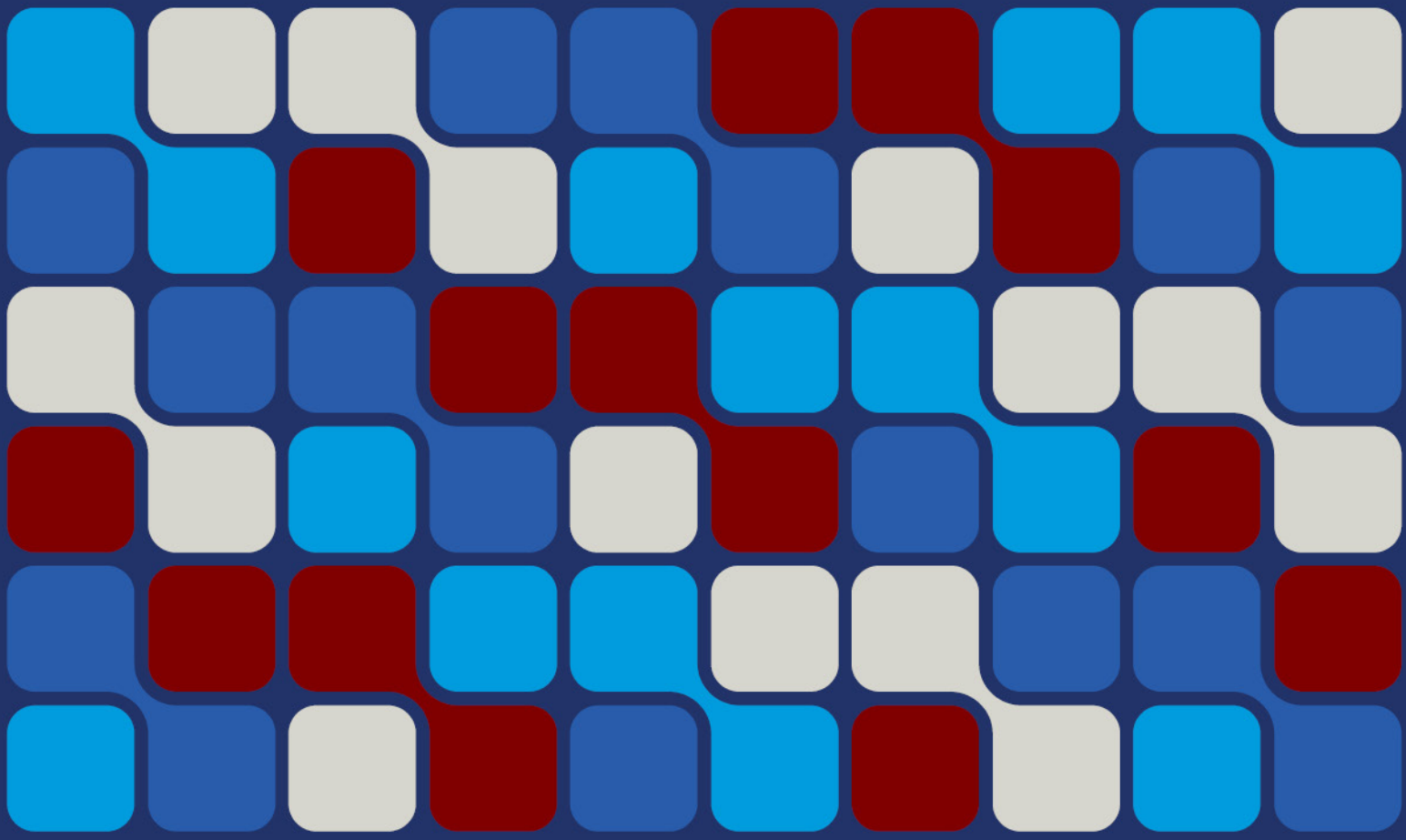

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DISCLAIMER

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INTRODUCTION

Across the social service sector and in communities nationwide, a consensus is emerging: there is a need to create a family and child well-being system that buoys families facing adversity and helps them thrive. This system must be designed responsively with the communities and families it serves. It must be precise in its mission and modeled with the specific scale and nature of American family adversity clearly in focus. Research provides a vivid picture of the intertwined economic and social strain affecting millions of families daily. In 2022, about one in eight children (12.4%) lived in poverty[1] and even more—one in five, or 20%— experienced food insecurity,[2] while a stunning one in four spent over 50% of their household income on housing in 2020.[3] Living and raising children at the edge of scarcity demands a level of resourcefulness and resiliency that taps caregivers' mental and physical capacity—as economic hardship degrade family dynamics in tandem with caregiver mental health, well-being, and parenting capacities.[4] Macro-economic forces can create an environment in which families are challenged to achieve economic stability. However, the services and supports designed to buttress and resource them are insufficiently funded to meet families' needs and often difficult to access, are spread across a fractured social service system, and are insufficient to meet basic needs. Economic security, and thus household stability, remain out of reach for many.[5,6]

When unmet family needs escalate as a result, mandated reporters call the hotline—leaving critical child protective services (CPS) systems inundated with the burden of sifting through millions of reports and conducting investigations. Ultimately, CPS investigates the caregivers of nearly 40% of all U.S. children by the time they turn 18. Child welfare is not designed to meaningfully help these families. Its predominant interventions of investigations and foster care focus on safety, rather than on families' underlying economic and social needs. In short, families facing adversity are often erroneously sent to child protective services for support that it, by design, does not provide.

This cycle of unmet needs and contact with child protective services brings into relief a *design flaw*: enormous numbers of American families find themselves in an abyss between health, economic, caregiving, and human services systems, where supports are either insufficient or unattainable, and family needs swell—only to find themselves in contact with child welfare, a system not designed to help them. This design flaw creates a deeply damaging cycle: families do not get what they need from inadequately supported health, economic, and social services, their challenges escalate, and they are referred to CPS. Then CPS, which lacks the right tools to help them, sends them back to an ineffective service and support system.[7]

The need is evident to design a system that supports families proactively without subjecting them to the often unnecessary and traumatic experience of involvement with CPS. Such transformative change will not be easy; nonetheless, a path forward is visible. Major policy shifts affecting children and families—such as Medicaid expansion under the Affordable Care Act, income and housing supports (particularly as part of the temporary pandemic response packages), paid family leave, and child care expansions—have been enacted at the state and federal levels in recent years. As a result, child poverty was temporarily cut in half from 2019 to 2021, only to rise again when pandemic-era policy innovations ended. But even though some of these improvements were temporary and have been reversed since the pandemic, others remain. Even those improvements not yet enacted permanently have contributed energy and ideas to a context ripe for change. On the child welfare side, the Family First Prevention Services Act has spurred innovation to redirect child welfare's focus to prevention.

These shifts create new opportunities to put in place a more holistic and prevention-oriented vision for serving children and families. Family First positions child welfare to cast a vision for transformation and partner with—or, in some circumstances, lead—the health and human services sector to deepen investment in upstream prevention.

This document aims to frame and describe an approach to proactively ensuring that families have what they need to thrive by resourcing and supporting families and reducing our nation's over-reliance on the inappropriate activation and deployment of child protection services. It is comprehensive, as it describes the full well-being system to provide an inspiration and a vision for the future. Yet it is also incremental, as the individual components offer a feasible way forward by filling gaps and addressing key pain points in the short term. It describes how public systems and programs as diverse as the Temporary Assistance to Needy Families (TANF), the Child Tax Credit, Medicaid, and Title IV-E can meet in the space between systems to integrate and strengthen their efforts to support families, creating an alternative system response and rendering the CPS function largely obsolete. The framework both synthesizes and builds upon a range of relevant advances and is designed to support system leaders and advocates at the national and local levels advancing new approaches for supporting families. It describes the core components and strategies to operationalize these new approaches. To fuel the design of policy solutions, the framework describes promising strategies, provides on-the-ground examples illustrating feasibility and lessons learned, and presents research evidence where available—framing the scale of what is possible.

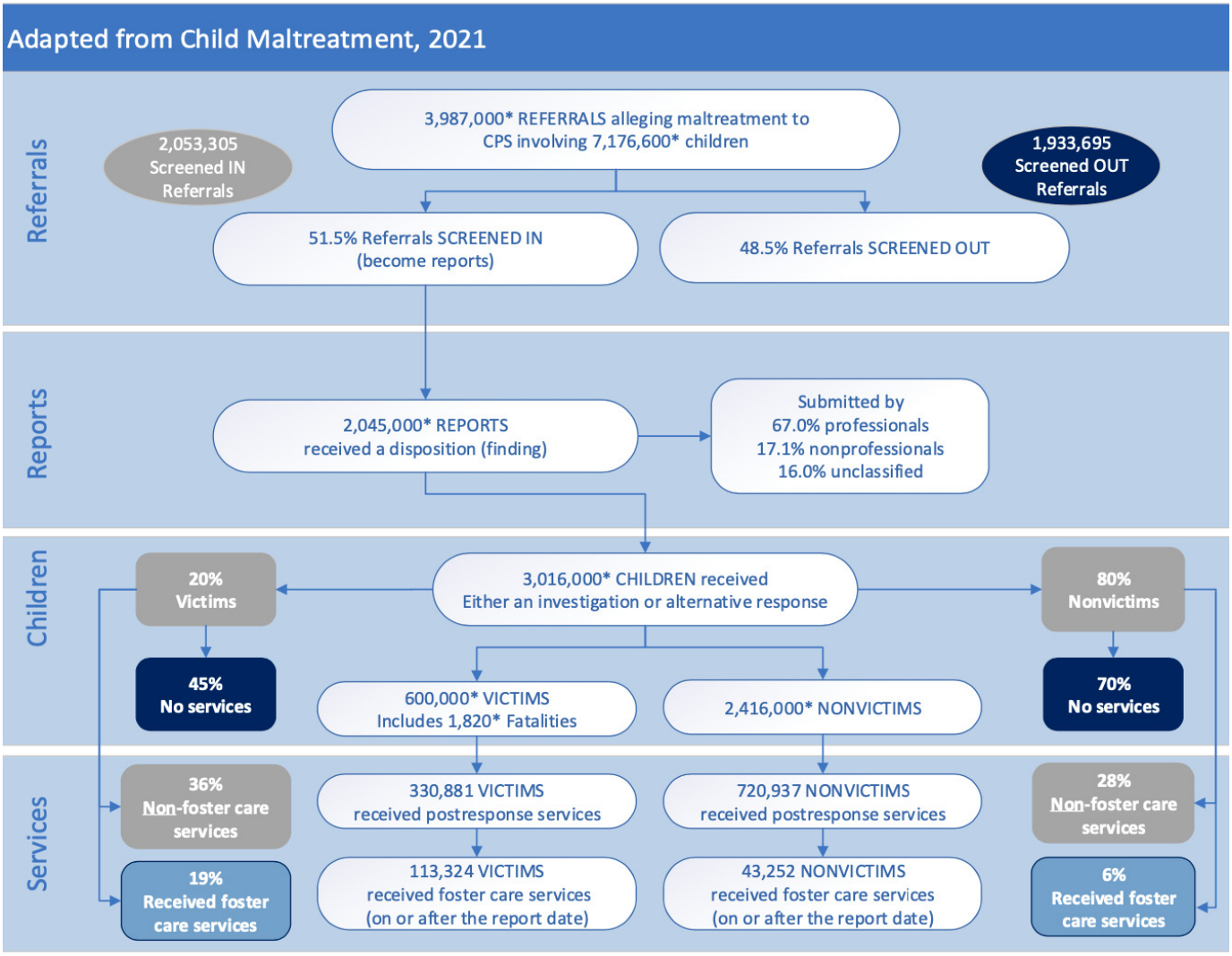
THE DESIGN FLAW: MISMATCH BETWEEN CHILD WELFARE INTERVENTIONS AND MANY CHILD WELFARE FAMILIES

Recent child maltreatment statistics[8] illustrate the system design flaw, demonstrating the quantity of referrals made to CPS and the number of families who are never served appropriately because their needs did not align with what child welfare offers. As shown in Figure 1, nearly 4 million referrals, involving over 7 million children, were made to child protective services in 2021. Approximately 2 million referrals were screened out. Upstream services and supports are either not sufficiently resourced or inaccessible to families in need. When families are in distress, mandated reporters and others activate CPS at high levels.

Unsurprisingly, screened out families, who were ineffectively supported upstream and then received no support from child welfare, often continue to struggle and are re-referred to CPS. A review of screened-out cases found that these families are at high risk of re-referral and share characteristics with those who were screened in.[9]

However, even those screened in at CPS rarely receive the support they need. For the 3 million children experiencing an investigation in 2021, 20% were determined to have experienced abuse or neglect, yet 45% of them received no services. Of the 80% who were determined to not have experienced abuse and neglect, 70% received no services.

Figure 1. Outcomes of Referrals to Child Welfare in 2021 in the United States



A consequence of our nation's overreliance on activating the CPS response is that nearly 40% of all U.S. children, and more than 50% of Black children, experience an investigation by age 18.[10] For families already experiencing instability—due to cumulative lack of resources, income shocks, or other complex challenges, like substance use—an investigation, even one that does not result in substantiation, threatens their family unity, leading to measurable decrease in well-being. Early research suggests that contact with CPS, independent of underlying maltreatment, may be associated with worse mental health and developmental outcomes in youth.[11] This design flaw results in a cycle of unmet needs and contact with child protective services, which likely further elevates family distress, repeated CPS referrals, and increasingly intensive and intrusive interventions.

This enormous volume of referrals, screen-outs, and investigations is not random. As it is currently designed, the upstream health and human services platform does not share responsibility and accountability for targeting resources to prevent or avert the activation or deployment of child protective services. Further, mandatory reporting laws have created a system of surveillance rather than a system of effective service delivery, in part because nearly every state imposes penalties, such as fines or imprisonment, on mandated reporters who fail to refer any concerns of abuse or neglect.[12] The animating question of the past 50 years has been: *Is the child safe?*

This focus has led to expanding referrals to CPS and extending the role of child welfare. There is also a general lack of awareness of ever-growing evidence that meeting the fundamental needs of parents and addressing complex needs with specific services, if indicated, help prevent abuse and neglect. A different animating question going forward, guided by the evidence, could be: *Are the caregiver and family getting what they need to thrive and keep children safe?*

The negative impact of this design flaw is most keenly felt in low-income communities and communities of color impacted by the blunt force of structural racism. Families of color have experienced deep inequities in income, wealth, and resource access over time.[13] They are disproportionately more likely to face volatile employment, material hardship, and economic insecurity due to longstanding systemic conditions and structural racism.[14,15] This fuels disproportionate referrals, by mandated reporters and others, of Black and Tribal families to child welfare. Moreover, racism and socioeconomic bias in public and private policymaking contribute to societal acceptance of the fact that services and support that could help low-income and families of color thrive do not receive enough resources. Racial disparities also occur at nearly every major decision-making point along the child welfare continuum. African American families are overrepresented in reports of suspected maltreatment,[16] are subjected to CPS investigations at higher rates than other families,[17] and, alongside American Indian or Alaska Native children, they are at greater risk than other children of being confirmed for maltreatment and placed in out-of-home care.[18]

Racially and ethnically diverse families also experience disparate treatment once they are involved with child welfare. Relative to other children, African American children spend more time in foster care[19] and are less likely to reunify with their families.[20] Compared with White children, they are less likely to receive services.[21]. As such, the child welfare system compounds existing inequities upstream, such as lack of equitable access to opportunity and resources, epitomizing structural racism.

WHAT FAMILIES NEED: DESIGNING AN ORGANIZING FRAMEWORK FOR AN INTEGRATED AND HOLISTIC FAMILY AND CHILD WELL-BEING SYSTEM

The primary question of whether the parent/caregiver and family are getting what they need to thrive and keep children safe could become the broad system orientation in the future. This would guide the creation of an *integrated and holistic family and child well-being system* that addresses the system design flaw and serves as a meaningful alternative to the activation of child protection for many families.

In order to be well and thrive, all families require reliable access to resources to meet basic needs, including food, shelter, and health care; a safe home and community environment; social connections; and services and supports that address their specific or complex needs. Many families will be unable to access one or more of these essential elements of well-being—either chronically or suddenly—because of an event like death, illness, job loss, cost increases, or natural disaster. But essential supports in those times are not accessible to all families or in every community. Prolonged periods without these elements of well-being can lead to individual, family, and community destabilization.

Why do families in need lack access to the supports and resources to stay afloat? While macroeconomic policies have contributed to the destabilization of lower-income families over recent decades, services and supports to families have crumbled. National and state policy choices have either not invested or not invested enough in supports designed to alleviate crisis. Additionally, available services and supports are often misaligned with meeting the basic needs of struggling families. To the extent that supports are available, administrative barriers and red tape can make accessing them extremely difficult—such as documentation requirements, tortuous application or renewal processes, and processing delays. Moreover, fractures and lack of coordination between family-serving systems can lead to redundancies and gaps in the service array. Systems then also fail to take responsibility for families, leading each siloed system to look to the other to help a family in crisis. Then, families fall through the cracks. The *integrated and holistic family and child well-being system* would call on the full spectrum of family-serving systems to invest and share accountability for families.

As a practical matter, there is a need for more visible, reliable, and well-resourced mechanisms for families, community members, and mandated reporters to turn to meet needs, even complex needs, when there is not an urgent safety concern. To create an integrated family and child well-being system, resources and policies need to be marshaled across the public and private sectors so that there is readily available and reliable capacity to effectively meet needs. This integrated and holistic family and child well-being system would ensure that all families have meaningful access to the array of resources, services, and social structures to meet their needs. It would have the capacity to provide sufficient and timely support, when necessary, in the least intrusive way possible. This would result in the human service sector and child and family serving systems focusing their efforts and resources—and collective responsibility and accountability[22]—on meeting child and family needs and preventing unwarranted child protection deployment.

A fundamental charge of government and a well-functioning society is to support families and avert the use of intrusive and punitive interventions, particularly those with the possibility of dissolving family unity and integrity.[23] An integrated and holistic family and child well-being system, inclusive of education, health, and public supports, would embrace its role to prevent the use of child protective services and promote family unity.

An integrated and holistic family and child well-being system would not only meet the fundamental needs of families but do so in a culturally responsive manner. Ways to achieve this include through services and supports codeveloped by families and by pursuing outcomes that matter to the broader community. Families and their communities would have an active hand in shaping and continuing to refine the redesigned system. They would be seen as the customers of this system and responsive customer service would be central. Through the federal executive order, Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government,[24] leaders were directed to account for the experiences of the public in the delivery of government services. Specifically, the executive order includes 36 customer experience improvement commitments across 17 federal agencies, all of which aim to improve people's lives and the delivery of government services. Transitioning to a customer service ethos with the inherent focus on designing human-centered systems concentrated on customer needs would enable the health and human service system broadly, and child welfare specifically, to focus on ensuring that families get what they need, when they need it, to reduce the unnecessary use of CPS.

FAMILY FIRST AND POLICY LEVERS: INFORMING AN INTEGRATED AND HOLISTIC FAMILY AND CHILD WELL-BEING SYSTEM

The Family First Prevention Services Act, passed in 2018, allows federal funds to be used to support needed prevention services and many of the strategies identified in the organizing framework (see later section). These funds have historically been reserved for supporting placements and associated administrative costs after children are removed from their homes. This new federal fiscal flexibility and policy direction are fueling new partnerships and innovative strategies across the country. This includes states developing community pathways[25] to increase access to evidence-based prevention programs and services and other supports, in some instances without relying on a call to child protective services or an investigation to identify families in need of support. ***Family First offers an opportunity to fund and implement targeted prevention services for families and children. While action is needed from multiple systems to realize a true well-being system, Family First provides an opportunity for* child welfare to initiate partnerships across the sector and engage in the work of transformation.**

Since Family First passed, states have developed statewide prevention plans for federal approval. Today, those plans are in the first stage of installation and on-the-ground implementation. While the amount of spending on prevention remains small relative to the amount of spending on out-of-home care,[26] there are early signs that entries into foster care are declining, suggesting movement toward the core policy intent of Family First.

The number of children entering foster care is on a downward trajectory from over 240,000 children in 2018 to about 175,000 in 2022, with the rate decreasing from 3.27 to 2.37 per 1,000 children.

Additionally, between 2018 and 2021, screened-in referrals to child protective services fell from 2.4 million to 2.0 million, with the screened-in rate decreasing from 32.5 to 27.6 per 1,000 children. The exact strategies and contextual factors yielding these reductions are not fully understood. However, states and communities across the country are implementing family resource centers,[27] community response programs,[28] home visiting,[29] care management entities,[30] and navigation hubs[31] to help families access resources, services, and peer support in an effort to reduce the unwarranted use of child protective services. Child welfare leaders are directing resources toward these strategies via Family First and other prevention spending while concurrently "narrowing the front door" of child protective services.

Some of these strategies are also operating as the service delivery platform for the community pathways many states describe in their Family First plans. "Community pathways" in this instance refer to any avenue or mechanism that families can use to access federally funded prevention services and supports outside of the traditional child welfare service delivery and case management context. Table 1 shows states with community pathways in their Family First plans. Importantly, states can submit Family First plan amendments at any time. Every 5 years a new plan must be submitted, providing critical opportunities to further innovate and leverage the policy and funding stream to better meet the needs of families upstream—where they live and in contexts they trust.

Table 1. States with Community Pathways in Family First Plans

CONCEPTUALIZING	READYING	IMPLEMENTING
Colorado	Arizona	Connecticut
Kentucky	California	Indiana
Oregon	Michigan	New Hampshire
Pennsylvania	New York	Rhode Island
South Carolina		Washington, DC
Washington state		

The goal of these states is to expansively use the Title IV-E funding stream available through Family First to meet family needs early, reduce risk for child protection involvement, build community capacity, and transform child welfare. Some advocates and parents who have experienced a CPS investigation have raised cautions regarding the possibility that this approach could increase surveillance of families and make intrusive interventions more likely. Some states are narrowly applying Family First only to those families for whom a child protection engagement exists, hoping to avert even deeper involvement. Both approaches strive to redress two of the defining features of racial and socioeconomic bias in policymaking. The first reduces resource deprivation and the second reduces surveillance. In each approach, states will use data and continuous quality improvement strategies to mitigate potential negative outcomes and determine if the anticipated shared goal of reduced involvement in child protection is being achieved.

Differential response (DR) systems in child welfare provide key learnings and an important foundation for community pathways and a prevention-oriented child and family well-being system. Beginning in the 1980s and 1990s, child welfare leaders who adopted a DR system recognized that a traditional child welfare investigation and child maltreatment determination was not the most appropriate or effective response for all families screened in at the child welfare hotline. Instead, they implemented an alternative response for eligible families focused on assessment and family engagement to determine what services or supports might be useful for promoting safety and well-being.[32] A prevention-oriented family and child well-being system learns from, but extends beyond, differential response by providing engagement and service access points that do not require activation by interfacing with the child welfare agency or calling the child welfare hotline. Moreover, it is important to note that differential response evaluation findings overall are favorable. A recent meta-analysis[33] spanning 2004–2017 showed that states with a DR program observed 19% fewer substantiated reports, 25% fewer substantiations for

neglect, and a 17% reduction in foster care when compared with states without DR programs. These data suggest that shifting the animating question from "How safe is the child?" to "Are the parent/caregiver and family getting what they need to thrive and keep children safe?" is likely to result in improved child and family outcomes.

ECONOMIC AND CONCRETE SUPPORTS TO PREVENT CHILD WELFARE SYSTEM INVOLVEMENT

Among the many upstream services and supports families need, research shows that economic and concrete supports[34] are the most critical. As described above, referrals to child protective services and ensuing involvement in the child welfare system are often driven by economic insecurity and cumulative material hardship.[35] An ever-growing body of evidence clarifies that when economic and concrete supports are provided—via public and private investment (such as the Earned Income Tax Credit, Child Tax Credit, child care, cash assistance, health insurance, or housing assistance) and labor market regulation (paid family leave, minimum wage)—child maltreatment and involvement with child protection are reduced.[36]

For CPS referrals that are screened out, the literature suggests that these families primarily have financial needs, are at risk of re-referral, and, as noted above, are not dissimilar to families who are screened in.[37] Many accepted referrals that are unsubstantiated are made to child protective services for issues that are also secondary to financial need. The strongest predictors of investigated neglect referrals relate to financial need, including food pantry use and cutting meals, difficulty paying rent, and utility shutoffs.[38] And of substantiated referrals, more than 60% are for neglect only.[39]

There are likely multiple pathways through which resource deprivation and scarcity lead to the deployment of child protective services.[40] In some instances, there is a direct link between the lack of resources, like housing, and a call to CPS. For example, it is estimated that inadequate housing contributes to the risk of entering foster care for 1 out of every 6 children involved in CPS investigations.[41] Another pathway relates to the Family Stress Model[42] and research findings on economic shocks,[43] suggesting that stressors related to household finances and income volatility have a unique relationship with child welfare system involvement,[44] particularly for families living at the edge of scarcity. Prolonged material need or significant material need that is unexpected may lead to parental stress that can compromise parenting capacity. Low-income families experiencing at least one material hardship are three times more likely to experience a neglect investigation and four times more likely to experience a physical abuse investigation. Sudden loss of income and resources that lead to multiple material hardships (such as loss of housing and child care) is an even greater risk factor, making a physical abuse investigation seven times more likely.[45]

Approximately 85% of families investigated by CPS have incomes below 200% of the federal poverty line,[46] suggesting that CPS is mainly deployed to families in poverty experiencing income volatility or complex needs. While substance use, mental health challenges and intimate partner violence are common among families who experience substantiated CPS investigations, having sufficient income to meet basic needs provides an important buffer. Families with higher incomes with similar complexities are less likely to be investigated. Additionally, when families have concrete supports, the risk of maltreatment is reduced. For example, mothers entering substance use treatment who reported difficulty finding child care were more likely to self-identify as neglecting their children than mothers entering treatment without child care access challenges. Difficulty finding child care was a stronger predictor of maternal neglect than almost any other factor measured in this study, including mental health and severity of drug use.[47]

Economic factors are also associated with child welfare involvement for reasons beyond individual-level parenting behaviors and capacities.[48] A recent secondary analysis of the National Academy of Sciences' *Roadmap to Reducing Child Poverty* said that "[r]eports alleging child maltreatment and, particularly, child neglect are disproportionately common among low-income families, and existing research suggests that **this link is only partially attributable to parental characteristics, suggesting that substantial resource constraints lead directly to an increased likelihood of CPS involvement"**[49] (emphasis added). Furthermore, in a recent national survey conducted by the American Public Human Services Association (APHSA) and Chapin Hall, 70% of state child welfare agencies reported that the inability to meet basic needs was a primary factor in family involvement with the child welfare system, with 100% of states reporting it as at least a secondary factor.[50] However, the current child welfare policy framework orients assessment and intervention predominantly at parenting behaviors and capacities, thereby not addressing this key driver of CPS investigations.

This preponderance of evidence regarding the relationship between economic and concrete supports and child welfare system involvement has accrued over the past 30-plus years and has implications for policymaking and system redesign. Nevertheless, there are repeated historical and contemporary policy decisions, including in the Family First Prevention Services Act, that separate resourcing families from interventions to address safety, thus maintaining siloed policymaking and limiting collective responsibility and accountability. States must move toward policy that addresses both safety and concrete needs of families in an integrated manner, while integrating human service programs to create a coordinated response that addresses the full range of needs. To actualize an *integrated and holistic family and child well-being system*, policies across the health and human service sector must be understood as prevention policies. These policies must be administered sufficiently and with intention to prevent the activation and deployment of the child protection system.

WHY THIS FRAMEWORK? WHY NOW? BUILDING ON EXISTING FRAMEWORKS THAT PROMOTE WELL-BEING

The concept of an *integrated and holistic family and child well-being system* has gained increasing recognition, and momentum is growing. Many states, jurisdictions and philanthropies are bringing new ideas, resources, and strategies to bear. Leadership from communities, families, and youth with lived experience in child welfare are also informing the direction forward. The present framework reflects and builds conceptually and empirically on this body of work, including the following:

- Thriving Families, Safer Children,[51] an initiative of the U.S. Children's Bureau, the Centers for Disease Control and Prevention, Casey Family Programs, the Annie E. Casey Foundation, and Prevent Child Abuse America, organizes around a public health framework to address the root causes of child abuse and neglect. This initiative centers solutions on the voices of families with lived experience. In doing so, it seeks to transform child welfare from a system that reacts to crises and focuses on individual-level solutions to one that proactively addresses context to enable large-scale change.

- Chapin Hall reviewed 20 years of initiatives that included efforts to create partnerships with communities as a strategy to generate systems change. The review included case studies, interviews, and a systematic review of the literature. Based on the lessons learned from a diverse array of initiatives, five strategic and actionable recommendations emerged: disrupt system mindsets and habits, invest in community, reimagine community engagement, transform systems with community in the lead, and embed community leadership and adapt over time.[52]
- The Birth Parent National Network and the Casey Family Programs Birth Parent Advisory Committee created a framework called *Building a 21st Century Community-based Approach to Strengthening Families.*[53] It includes strategies to create a humanitarian society, supportive and healthy communities, strong and stable families, and safe and healthy children.

"We and other parents are important contributors to the growth of healthy communities and bring valuable information, resources, experiences, and solutions. We are ready to partner with service providers, national, state, and local leaders, and systems to create supportive communities that include a comprehensive prevention approach."

– Birth Parent National Network and Casey Family Programs Birth Parent Advisory Committee

- The Harvard Kennedy School Government Performance Lab's resource *The Journey to a Well-Being-Oriented System* identifies eight domains where innovation must occur to support creation of a prevention-oriented child and family well-being system. The resource describes five levels of maturity within each domain, offering a practical tool for government leaders to scaffold advancement toward system transformation.

Many additional frameworks have similar goals:

- The World Health Organization's *Conceptual Framework for Action on the Social Determinants of Health*[54] clarifies the necessity of including strategies targeting socioeconomic and political context.
- In 2016, the Centers for Disease Control and Prevention released *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*,[55] which highlights the need for cross-sector contributions to prevention that contribute to safe, stable, and nurturing relationships and environments. This also includes strengthening economic supports for families, providing quality care and education early in life, enhancing parenting skills to promote health child development, and intervening, when necessary, with evidence-informed strategies.
- Two-generation approaches also focus on building well-being, centering the whole family, and promoting positive outcomes for everyone. Ascend at the Aspen Institute's *State of the Field: Two-Generation Approaches to Family Well-being* describes the five key areas for action: health and mental health; early childhood development, learning, and care; postsecondary and employment pathways; economic assets; and social capital.[56]
- The National Foundation to End Child Abuse and Neglect, with its partner Values to Action, will soon release a call to action for *Mobilizing America to End Child Abuse and Neglect* that includes aligning cross-sector partners, engaging media to frame mental models and public perception, and building political will.

- This need for mental model and narrative change as core to transformation is well described in *The Water of Systems Change*[57] and operationalized as it relates to reframing childhood adversity and promoting upstream prevention by the FrameWorks Institute.[58]

These visionary resources have inspired a shift in mental models for how government can support families and guided system transformation across the country. Building on these foundational resources, **the present framework contributes to the conversation by addressing the *design flaw*—**describing how public systems and programs as diverse as Temporary Assistance to Needy Families (TANF), the Child Tax Credit, Medicaid, and Title IV-E can meet in the space between systems to create a stronger, more integrated, and more preventative system response and render the CPS function largely obsolete. **The framework posits that child welfare can serve as a catalyst, help shape the vision, be a highly effective partner, bring resources to bear, and, in some circumstances, lead—but cannot achieve system transformation alone.** It blends a public health approach with system re-orientation. The framework is grounded in Chapin Hall's guide stars: deep knowledge of the national implementation landscape and the direction of evidence-based policymaking. Accordingly, this framework lives at the nexus of implementation, policy, and evidence, reflecting a scan of progress in jurisdictions, innovative policy and guidance, literature, and research findings.

The timing is right for transformational change in child welfare and across the health and human services sector. While Family First has shifted the focus of child welfare leaders to prevention, parallel innovations are occurring in other sectors, motivating collective action. In the health sector, the years since implementing the Affordable Care Act in 2013 have seen large expansions in health coverage, changing the funding landscape for health and behavioral health supports for parents, at least in states that have enacted Medicaid expansion (most recently, North Carolina in 2023). There is also growing recognition of the need to identify and address the social determinants of health (for example, housing and food insecurity) and adverse childhood experiences, many of which relate to child maltreatment, substance use, mental health needs, and loss of a parent. In the same vein, TANF innovations are underway, such as a universal direct cash transfer program in Flint, Michigan, that leverages a combination of TANF and private funds.[59] Paid family leave policies have now been enacted in 12 states and the District of Columbia, and a child care guarantee came within one vote of national enactment in the U.S. Senate, with a number of states taking major action.[60] Partnering across sectors and leveraging these innovations increases the likelihood that an *integrated and holistic family and child well-being system* is possible.

ORGANIZING FRAMEWORK AND STRATEGIES: GUIDING A WAY FORWARD

PURPOSE

The framework is designed to be at once both *visionary and practical,* crystallizing in actionable terms a blueprint for a paradigm shift: an integrated and holistic family and child well-being system.

Policy and system transformation hinge on creating a meaningful alternative so effective that it makes the less effective (or damaging) approaches deployed by the child welfare system largely obsolete for many families. The meaningful alternative can then become the primary approach to meeting family needs, and, as a result, the demand on the traditional child protection system can be substantially reduced. CPS can then serve its original purpose: addressing egregious cases of abuse and neglect. Said differently, implementing this framework would fill the existing family engagement and service delivery gap and address the system design flaw of overreliance on the child protection system. We anticipate that it is possible to better meet the needs of families by combining existing innovative and new strategies with peer learning and intensive guidance and support from an array of national child welfare and human services experts with lived experience. Moving beyond siloed thinking, the framework elevates the need to purposefully link many of the existing concepts and strategies to create a new holistic and integrated well-being approach. The framework can serve as an iterative platform for refining *a collective way forward toward creating an integrated and holistic family and child well-being system—one that meets family needs and focuses on preventing unnecessary activation and deployment of child protection.*

OVERVIEW OF FRAMEWORK

Key elements of the framework are: (1) assessing *foundational conditions for change* and (2) choosing actions that will move the community-wide service system closer to the vision, using the *six components of system change*. Eventually, communities seeking change will build strength in all six of the components, but the starting point and the path will depend on existing needs, strengths, and opportunities.

Assess foundational conditions for change. In considering how to get started, framework users should assess the strengths and weaknesses of their community service array relative to family needs. Items to consider include programmatic strengths and gaps, strengths and gaps for particular families and neighborhoods (especially those most marginalized), and capacity or lack thereof for collaboration. Two *foundational conditions for change* are especially important in deciding how to proceed:

- shared leadership with families with lived experience and
- collaboration, synergy, and shared accountability across human services programs and agencies.

Agencies that are not far along on the first criterion—that is, they are not closely connected with people who have lived experience of the system and do not have regular mechanisms for seeking feedback and sharing decision-making—are not yet ready for the action phase of a major change effort. However, exploring the community's needs, strengths, and priorities for prevention services and related infrastructure using this framework could be a way to start building the necessary relationships and creating the capacity to implement change. Similarly, agencies that do not have strong collaborative relationships with human services and health partners are likely not ready to develop an action plan, but they can use this framework to jump-start the needed conversations.

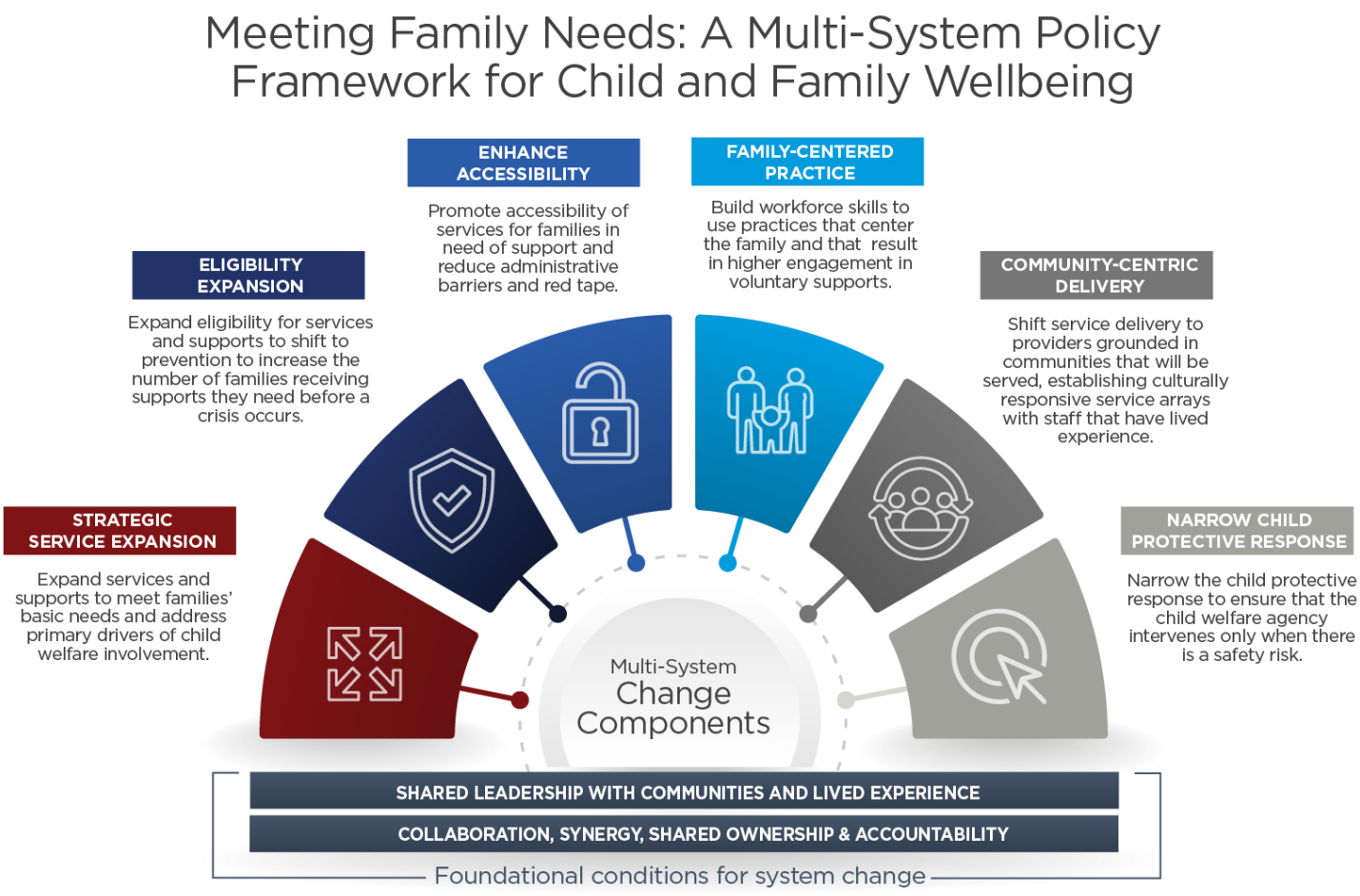
Choose actions based on the six components of system change. The core of the framework consists of six types of practical steps a jurisdiction can take towards the vision of comprehensive change, as summarized below:

- **Strategic Service Expansion:** Expand services and supports to meet families' basic needs and address primary drivers of child welfare involvement.[61]
- **Eligibility Expansion:** Expand eligibility for services and supports to shift to prevention to increase the number of families receiving supports they need before a crisis occurs.
- **Enhance Accessibility:** Promote accessibility of services and supports for families in need of support and reduce administrative barriers and red tape.
- **Family-Centered Practice:** Build workforce skills to use practices that center the family and result in higher engagement in voluntary supports.
- **Community-Centric Delivery:** Shift service delivery to providers grounded in communities that will be served, establishing culturally responsive service arrays with staff that have lived experience.
- **Narrow Child Protective Response:** Narrow the child protective response to ensure that the child welfare agency intervenes only when there is a safety risk.

Eventually, a successful prevention strategy will include all of these, but each agency—reflecting in partnership with advocates, community leaders, service providers, people with lived experience, and colleague agencies—may choose to start in a different place. Ideally, agencies will begin with actions that are doable and make a major difference to families' lives. As jurisdictions consider which strategies to pursue, considerations may include (a) jurisdictional readiness for individual strategies, prioritizing strategies where foundational resources, capacity, and motivation to adopt the change are already in place (b) fit with the jurisdictional context and need, prioritizing strategies that target identified areas of high need or have a track record of impacting identified priority outcomes, and (c) sequencing, adopting related strategies in tandem or in an intentional sequence.

Figure 2 displays a summary of the full framework.

Figure 2. Policy Framework for Family and Child Well-being: Summary



HOW TO USE THE FRAMEWORK

The child welfare and broader health/human services/economic supports/caregiving communities are invited to use this framework in several different ways to make progress on the vision of *a holistic and integrated family and child well-being system*. In particular, users of the framework may wish to take one of the following three approaches, knowing that individual leaders and communities will surely identify many more.

Approach #1: Use the framework as a catalyst to build stronger collaborations with people with lived experience and across agencies. In jurisdictions where collaborations need to be strengthened, we would encourage using this framework to kick off conversations and build relationships. We anticipate that it could stimulate excellent shared discussions around issues such as: How do families with lived experience see the system mismatch described above? What service and access gaps, and what mismatches or failures within the child welfare system, are most striking to them? How might the agency, advocates, and people with lived experience jointly collect data or otherwise work through some of these questions of priorities? Similarly, what service and access gaps and what mismatches or failures within each of the agencies are most striking to people engaged (as public officials, people with lived experience, or advocates) across the human services systems? How might these different systems jointly collect data or otherwise work through their perspectives on the obstacles and the opportunities for change?

These and other questions could potentially help build relationships and help institutions be ready for the next phase: action planning.

Approach #2. Use the framework to create, expand, or sequence action plans in the context of strong existing relationships with people with lived experience and across health and human services partners. In communities and jurisdictions that are more ready to commit to a holistic and integrated family and child well-being system, the framework can serve as a basis for strengthening commitment. The framework could help turn a general vision into an action plan, expand an existing action plan, or more explicitly sequence actions to reach the goal. For example, if an existing action plan to strengthen preventive services only addresses two or three of the components, falling short of what is needed for system transformation, the framework could help the jurisdiction identify actions in the other areas. Or, if the existing plan is narrowly focused on particular segments of economic or social supports, the framework could stimulate thinking about other areas that would benefit from collaborative work—for example, Medicaid or child care in a jurisdiction that has focused on income supports.

Approach #3. Use the framework to engage the child welfare community in existing work by the health, human services, and caregiving systems. We expect that the first users of the framework will often be in the child welfare community. However, we hope that, in some jurisdictions where the child welfare agency is not currently engaged in a prevention focus, primary users of the framework may be health and human services communities. This could include agencies, people with lived experience, community leaders, or advocates who might use the framework to draw child welfare into the conversation. For example, the health agency in a jurisdiction with a recent Medicaid expansion may realize that it now has new tools to address behavioral health issues affecting parents and children. It may further realize that engaging the child welfare system in a prevention plan drawing on this new capacity should be a priority.

SOURCES TO SUPPORT USING THE FRAMEWORK

The full framework includes a complete list of sources and jurisdictional examples designed to support action and effective use of the framework. Users of the framework may wish to explore these sources and examples more deeply to understand what is possible and how it could be done.

THE ORGANIZING FRAMEWORK

ORGANIZING FRAMEWORK: BLUEPRINT FOR AN INTEGRATED AND HOLISTIC FAMILY AND CHILD WELL-BEING SYSTEM

Foundational Conditions for Change

Jurisdictions may want to boost the feasibility and accelerate the pace of conceptualizing, designing, and operationalizing an integrated and holistic family and child well-being system that includes one or more of the components and strategies outlined within the framework. They can achieve this by concurrently developing and building capacity to sustain the following foundational conditions for change:

1. **Shared leadership with communities and families with lived experience**[62,63] through human-centered co-design. Building systems that proactively address the unique needs of the families they serve requires deeper exploration of those needs, and it calls for power sharing between agencies, communities and families in policy and system planning. In practice, this consists of establishing decision-making processes where families and community members play leading, influential roles. To enable families to robustly contribute in these roles, barriers to full participation must be proactively identified and addressed, leveling the playing field and fostering a context where true co-design can flourish. Rather than asking families to provide feedback on drafts or plans already underway, agencies should engage them before decisions are made.[64] Families should be afforded formal responsibilities and leadership roles, allowing them to both inform system change decisions and shape the change process itself. As stated in Chapin Hall's *System Transformation Through Community Leadership* series "when communities bring their skills, insights, and experiences to the table, they can open the door to more transformative and antiracist ways of working."[65]
2. **Collaboration, shared responsibility, and accountability across the health and human service platform** to support families with meeting their basic needs and preventing the deployment of child protective services. Child welfare can lead this integration by initiating collaboration and demonstrating what's possible through targeted system changes such as implementation of Family First—knowing that ultimately no one system—not child welfare nor any other—can or should unilaterally address family needs. Multiple systems already play some role in supporting families upstream, albeit with insufficient resources and absent the coordination necessary to be truly effective. As we aim to proactively meet family needs, our guide star must be that *integration is innovation*: that establishing the shared responsibility and coordination that our systems have lacked for decades is a foundational condition for success. Only through aligning and strategically integrating government functions as diverse as behavioral health, K-12 education, Medicaid, disability, and TANF (to name a few) can an integrated holistic family and child well-being system be fostered. This may entail aligning eligibility and enrollment; service coordination where agencies offer related programs; a financing structure reflecting braided funding with aligned requirements to streamline administrative burdens; and technology integration across the public and private family-serving sectors.

COMPONENTS OF SYSTEM CHANGE

Below are the six overarching system change components essential to building a holistic and integrated family and child well-being system. Within each component, promising strategies are described. The strategies are not exhaustive, but they reflect key existing innovations and are a starting point for planning transformation efforts.

System Change Component 1: Strategic Service Expansion

To prevent contact with child welfare systems and promote thriving, families require access to a diverse array of voluntary, accessible supports and services to meet a range of child and family needs. While every jurisdiction will require a different strategic approach, it may be particularly helpful to consider increased investment in evidence-informed or promising interventions that (a) aim to meet families' basic needs, as a foundation for family and community stability across diverse beneficiary populations[66] and (b) address specific family needs that are primary drivers of child welfare involvement.[67] Notably, funding a support or service is not enough; low supply and barriers to access can still exist. Strategies to enhance engagement of community-based providers, promote a strong workforce, and ensure access to the services can be deployed in conjunction, as discussed later in this framework.

Promising Strategies

a. Invest in increased supports to meet families' basic needs, including:

Economic and concrete supports

Economic and concrete supports to promote economic stability and mobility through housing, nutrition, child care, and cash. The central role of economic and material hardship as a key driver of family involvement with the child welfare system has been well-established by the research literature and clearly underscores the importance of addressing the concrete needs of families and promoting economic stability.[68,69] Economic shocks in the lives of families are associated with increased risk of involvement with child protective services.[70,71,72] For families who are low income, in particular, experiencing material hardship (such as housing, food, utilities, medical hardships) is associated with an increased risk for both neglect and physical abuse investigations.[73] Therefore, while evidence-based programs remain an important approach for families needing more support, addressing economic hardship can be a first-line strategy in preventing and addressing child welfare system involvement.

- Kentucky provides up to $1,000 in flexible funds to meet the concrete needs of families receiving family preservation services. Up to an additional $4,000 per family is available through community action agencies for families with active CPS cases, including investigations, alternative response, and ongoing cases, as well as for families diverted from CPS and receiving supports through Community Response.[74] Finally, flexible funds are also available further upstream to meet the concrete needs of families not involved with the child welfare system who are receiving voluntary in-home services through Community-Based Child Abuse Prevention (CBCAP)-funded Community Collaboration for Children.[75]
- New York state will be piloting a direct cash transfer to families who have been referred to child protection and would have otherwise received differential response in order to test if re-reports to CPS can be prevented. The 150 families in the pilot will receive $500 a month for a year. It will be the first state in the nation to test a cash transfer effort in the child welfare context.
- Indiana's Intensive Family Preservation Services centers concrete supports to families. A recent evaluation found that the service reduced repeat maltreatment at both the case and child levels.[76] In addition, families in Indiana who do not have an open child welfare case can refer themselves or be referred by community agencies to Community Partners for Child Safety (CPCS), a longstanding upstream prevention effort which connects families to resources and includes flexible funds to meet families' concrete needs.[77]
- California makes available up to $1,000 for a one-time payment for the purchase of material goods to families participating in the TANF home visiting program.

- New Mexico is developing a free, universal childcare system after passing a ballot measure guaranteeing a constitutional right to early childhood education. Child care is currently free for families of four earning up to $111,000.
- Wisconsin is providing short-term housing funds to families with children at risk of removal due to housing insecurity. The funds can cover short-term rentals, hotel costs and expenses related to finding and maintaining housing.

Family resource centers

Family resource centers are community-based hubs that offer a range of supports, resources, and opportunities designed to strengthen and connect families while promoting the relational health and family networks that bind supportive communities. They are flexible, family-focused, and culturally sensitive, providing programs and targeted services based on the needs and interests of families. They can be located in diverse community settings, including schools, health care locations, day care facilities, housing projects, or community-based organizations. Family resource centers support the development of strong communities of support for parents and caregivers. Several assessments of family resource center outcomes have included the following findings:[78]

- Statistically significant gains in family self-sufficiency, reduction in subsequent child welfare involvement, and cost savings in Teller County, CO
- A 45% reduction in cases of child abuse and neglect in Alachua County, FL
- Significantly lower rates of child maltreatment investigations in communities with family resource centers in Allegheny County, PA.
- A 20% increase in parents' self-reports on their ability to keep the children in their care safe from abuse in Massachusetts.

Key jurisdictional implementation examples include the following:

- The New Jersey Department of Children and Families operates 37 Family Success Centers in underserved communities statewide with the goal of strengthening families and preventing maltreatment. Each site furnishes a welcoming and home-like environment where community members can engage in family-friendly activities and access the resources they need to thrive. Each site provides access to information about parenting and child development, as well as resource navigation to help families not only identify but also access services and supports such as housing, job readiness supports, concrete supports, and life skill support.[79]

Community action agencies

Community action agencies connect families to services including high-quality early education, job training for parents, stable and affordable housing, food and concrete supports, and utility assistance. Founded through the 1964 Economic Opportunity Act to combat poverty as part of the War on Poverty, over 1,000 Community Action Agencies exist across the country with the goal of helping low-income families achieve economic security. Annually, Community Action Agencies reach over 6 million families with nearly 4 million children.

The Community Action Network receives primary funding through the Social Security Block Grant. While the specific services and supports are shaped by individual communities, the most common services offered are Head Start, as well as Department of Energy programs designed to support low-income individuals and families: the Low Income Home Energy Assistance and Weatherization Assistance programs.[80] The Community Action Network has deep ties to communities and centers community decision making in the codesign of services and supports.

- Kentucky child protective services (CPS) has partnered with the statewide Community Action Council to assist in disbursing funds to assist families in need of concrete goods and services to reduce barriers to successful parenting. Funds can be used toward housing assistance; environmental needs such as pest control, transportation, and weatherization; medical and mental health needs; and housing supports such as beds, bedding, appliances, and cleaning supplies. $4,000 in flexible funds is made available per family through community action agencies.[81] Funds are available to families with open CPS, ongoing, and alternative responses cases.

b. Invest in services designed to address primary drivers of child welfare involvement.

Substance use services designed specifically for caregivers[82, 83]

Knowing that traditional SUD treatment programs and modalities often do not fit with the needs and circumstances of families, wide availability of such services designed specifically for caregivers could greatly increase accessibility and relevance. As stated in the Harvard Kennedy School Government Performance Lab's publication *The Journey to a Well-Being-Oriented System*, such services may include, for example, "models that combine substance use disorder treatment with attachment-focused therapy, family-based residential treatment programs and improved accessibility of standard SUD service models for parents (e.g., outpatient services that provide childcare)."[84] (p. 6)

- The Community Doula Support Program offered through Philadelphia Department of Health supports pregnant and postpartum parents, with a focus on parents with a history of substance use disorder. The program offers individualized support by a doula throughout pregnancy, birth, and up to 12 months postpartum. A new study shows that the program may help reduce fatal drug overdoses in the postpartum period and strengthen long-term engagement with addiction recovery services. [85]
- Sobriety Treatment and Recovery Teams (START) is an evidence-based intervention specifically designed to serve families with child welfare involvement where a caregiver has been diagnosed with a SUD. START promotes parental SUD recovery while also aiming to keep children safe and families together. This is accomplished through an integrated combination of SUD recovery services, counseling, and parent coaching. START is approved through the Title IV-E Prevention Services Clearinghouse for reimbursement through the Title IV-E prevention program.[86]
- California has implemented a contingency management (CM) program and is the first state to receive federal approval of CM as a benefit in the Medicaid program. CM is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder. Beneficiaries participate in a 24-week outpatient program, followed by 6 (or more) months of additional recovery support services. Individuals earn motivational incentives in the form of low-denomination gift cards, with a retail value determined per treatment episode.[87]

Accessible behavioral health and wraparound supports for youth

Young people need supports embedded in the places that are most familiar, such as schools and local clinics, and that are equipped to address routine stresses (currently at an all-time high following the pandemic) and acute crisis needs. Requiring youth to transition between providers when their needs change can be abrupt and disruptive; bolstering the care they already receive with wraparound supports deepens their ties to community and is less burdensome for the entire family. Coordinating eligibility requirements so that families find "no wrong door" during a crisis makes them more likely to connect quickly with the care they need before a removal or

inpatient care is required. Such supports can allow youth to stay connected to their families and communities as they heal and prevent youth from entering (and, likely, ultimately aging out of) foster care.

- The Integrated Care for Kids (InCK) model was developed and funded by the CMS Center for Medicare and Medicaid Innovation (CMS Innovation Center) to improve outcomes for Medicaid-enrolled children with complex physical, mental, and behavioral health needs who require a broad range of health and health-related services. InCK aims to identify needs earlier and ensure appropriate treatment for medical and behavioral health needs, with a key goal of preventing unnecessary out-of-home placements through better prevention upstream. A key function of InCK is to promote care coordination beyond healthcare to include partner systems that families rely on, such as education, housing, child welfare, cash assistance, and juvenile justice. InCK was piloted in seven localities nationwide starting in 2020. InCK is funded as a demonstration through section 1115A of the Social Security Act.[88] Drawing on lessons learned from InCK and other Innovation Center models, in January 2024, CMS announced the Innovation in Behavioral Health (IBH) model, which will test diverse approaches to improving care quality for individuals with mental health conditions or substance use disorders through a focus on increasing integration and coordination. The model promises to significantly accelerate innovation around the integration of behavioral, physical, and social care in the coming decade in selected jurisdictions.[89]
- The Mobile Response and Stabilization Services (MRSS) intervention in New Jersey provides immediate support for any family in crisis due to a child's escalating emotional or behavioral needs. An MRSS worker is available within 1 hour to help de-escalate, assess, and develop a plan together with the child and family. MRSS is accessible through a toll-free phone number, which serves as a single point of entry to a range of supports. The vast majority (94 to 98%) of young people served by MRSS are able to remain in their current living situation despite significant needs and challenges. This program represents one important component of a holistic approach to youth behavioral health and can be funded through Medicaid.[90]
- New Hampshire is using a multipronged approach to meet the needs of youth in their communities. Strategies include wraparound supports for stabilization and to promote the success of home and community-based services as a viable alternative to foster care and residential placement.[91]

Culturally specific services and programs

Culturally specific services and programs not only consider the role of race and culture as integral to developing solutions to challenges families face, they are also developed by and for people of color. Given that tribal communities and communities of color are most impacted by systemic racism and child welfare system involvement, these groups need a broader array of programs and services that address their needs. To that end, resources should be devoted to building the evidence base and effectiveness of culturally specific interventions so that they are eligible for investment through government contracts and can reach the families who need them most.[92]

- The evidence-based program Familias Unidas explicitly considers the dynamic between first-generation Hispanic immigrant parents and acculturating adolescents in contributing to family conflict, thereby increasing the risk of adolescent substance abuse.[93] Similarly, the developers of the Strong African American Families Program (SAAF) consider the ongoing experience of racism as a contributor to the risky behavior of African American youth.[94] Both of the interventions include culturally specific strategies to address the role of culture and race in addressing the underlying problem.[95]

Services and supports specifically targeting formal and informal kin caregivers

This may include expanding access to certain benefits and programs for relative and fictive kin caregivers, creating new or more robust services specifically for kin (such as kinship navigation models), or revising statutes and protocols around which families receive financial support for caring for children in their homes and the amounts families receive. For every one child in foster care living with a relative, there are 18 more non-child welfare involved children living with kin.[96] Informal kin caregivers represent racially and ethnically diverse communities and are more likely to be poor than other families, though they are often not offered or eligible for the services and supports they need for the stability and well-being of their families. Expanding access to services and supports to informal kin caregivers is an integral part of a child and family well-being system focused on upstream prevention.

- OhioKAN, Ohio's statewide kinship and adoption navigation model, is one jurisdictional example of a more generous and flexible kinship support program targeting families that are, and are not, currently involved with the child welfare system. OhioKAN provides assessment, information, referral, and collaborative support services to kinship and adoptive families at the level of intensity determined by the family. Importantly, OhioKAN includes informal kin caregivers as an explicit target population. This extends the opportunity for supportive resources to families who do not typically have access to supports and services at the same level as formal relative foster parents. In addition, regional advisory councils have been established statewide to inform and sustain OhioKAN implementation and the development of a service array that aligns with the identified needs of kin families in their community.[97]

Home visiting programs

Home visiting programs are voluntary supportive services that provide critical parenting supports and connections to community resources for families with young children. These programs are a key component of an upstream prevention continuum, as a universal or targeted support. Home visiting programs that are widely implemented through the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and Family First (such as Healthy Families America, Nurse Family Partnership and Parents as Teachers) typically limit enrollment to caregivers who have higher needs, such as those experiencing addiction, poor mental health, family violence, or who have prior trauma. Indeed, many programs are designed to serve and have strong outcomes with these families, including demonstrated effectiveness in preventing child abuse and neglect. In addition, research demonstrates that universal short-term home visiting programs, provided to all families with newborns in a community regardless of socioeconomic status, have the potential to reduce population rates of child welfare involvement. For example, Family Connects is a community-wide postpartum nurse home visiting program that assesses families' material needs, connects families to resources, and provides education and intervention as needed.[98] Randomized clinical trials demonstrate that families who were referred to Family Connects experienced 39% fewer CPS investigations through age 5, compared with families who didn't participate in the program.[99] The MIECHV- and Family First-funded home visiting programs offer infrastructure that can be leveraged for expansion in states that wish to target broader populations.

- The New Jersey Department of Children and Families allocated $44 million to provide universal home visiting using the Family Connects model on a voluntary basis statewide. It is the second state to offer home visiting to families of all backgrounds and incomes and be available to birth, adoptive, and resource families.[100]
- Indiana includes Healthy Families America in its Family First Prevention plan. Families receiving Healthy Families America are categorically eligible for Family First funding, thereby allowing for braided MIECHV and Title IV-E funding to increase capacity and reach families before abuse and neglect have occurred.[101]

System Change Component 2: Eligibility Expansion

Expand eligibility and target beneficiary populations to shift toward prevention, increasing the number of families receiving services and supports before a crisis occurs. Eligibility rules associated with social programs—including but not limited to major federal programs like Title IV-E, Medicaid, and TANF—have historically allowed for intervention with families predominantly after a crisis has occurred or needs have deepened, missing the opportunity to intervene early and in a truly proactive manner. While that tendency typically remains, some federal policy changes and demonstrations in recent years have provided an opportunity for states to expand eligibility to focus more on prevention, collectively signaling a policy direction across the health and human services continuum toward upstream prevention and holistic care. By expanding eligibility rules to reach families more broadly—either by offering service eligibility at the population level or by adapting eligibility criteria to reach families earlier—systems can proactively promote thriving, obviate more expensive and intrusive downstream services such as child welfare, and bring increased funding and revenue maximization to upstream prevention. Research demonstrates that state policy options for increasing access to economic and concrete supports are associated with decreased risk for child welfare involvement. For example, expanding eligibility by increasing income limits, eliminating asset tests, and establishing categorical eligibility across programs can reduce the risk for child welfare involvement. States with more flexible program policies for child care subsidies (including flexibility around eligibility) for child welfare-supervised children have, on average, fewer child removals than other states.[102]

Promising Strategies

Redefine "medical necessity" for Medicaid-funded mental and behavioral health services.

Within their Medicaid programs, states have untapped flexibility to redefine "medical necessity" criteria to increase access to mental and behavioral health services.

- Under California's Medicaid program, Medi-Cal, young people are eligible for family therapy benefits based not only on a mental health diagnosis, but also on certain life experiences. These life experiences include: separation from a parent/guardian, death of a parent/guardian, foster home placement, food insecurity, housing instability, exposure to domestic violence or other traumatic events, maltreatment, severe and persistent bullying, experiencing discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability. Thanks to eliminating the diagnostic requirement and re-imagining "medical necessity" for services, young people can address traumatic life events more readily and without stigmatizing or pathologizing these experiences, which often accompany poverty, racism, and community hardship[103]

Eliminate policies restricting access to TANF income

Research shows that, in general, policies restricting access to TANF benefits, including sanctions for not meeting work requirements and time limits, are associated with increased risk for child welfare involvement.[104]

- Oregon removed full-family sanctions, which take away TANF benefits from the entire family if a parent does not meet work requirements, by assigning 75% of the monthly cash grant to dependent children. This policy change recognizes that moving away from full-family sanctions can help keep children at home and with their families.[105] It also acknowledges the first statutory goal of TANF, which is to provide assistance to needy families so that children can be cared for in their own homes or with relatives.

Build Family First community pathways

Build Family First community pathways, mechanisms that families can use to access Title IV-E funded prevention services outside the traditional child welfare service delivery and case management context. This would effectively expand Title IV-E prevention services upstream, well beyond the traditional child welfare population. Investing in community pathways to prevention services creates an alternative to the established child welfare paradigm. Options to implement community pathways include, but are not limited to: (1) contracted community-based agencies (Family Resource Centers); (2) specific evidence-based prevention service providers (home visitors); and (3) non-child welfare public agency partners (departments of homelessness, behavioral health, public assistance). Within a community pathway, approved entities may perform the required Family First administrative functions to facilitate access to evidence-based practices, substantively shifting family-serving functions outside of child welfare. Several examples of emerging community pathways were described in a Casey Family Programs brief.[106]

- Connecticut is implementing a community pathway to Title IV-E prevention services and other supports for families by partnering with a care management entity (CME). CMEs are, a contracted partner located in communities across the state charged with engaging families and performing all duties associated with administering Title IV-E prevention services. Connecticut and the CME are strategizing how best to engage and educate mandated reporters, beginning with teachers, about using a CME. Specifically, mandated reporters need to know when it is more appropriate to refer families to the CME for supportive services rather than defaulting to a call to Connecticut's child abuse and neglect hotline. This allows child welfare system involvement to be avoided altogether when appropriate. Through the CME, families will be connected to peer mentorship, evidence-based practices, and economic and concrete supports.
- As noted above, Indiana is leveraging its partnership with Healthy Families Indiana (HFI) to implement its community pathway to Title IV-E prevention services. The HFI home visiting workforce will perform the administrative responsibilities associated with the Title IV-E prevention program. They will also use existing HFI assessment tools and case plans. As a result, more families at risk of child maltreatment will have access to HFI without needing to first come through the doors of the child welfare system to receive beneficial home visiting services.
- The District of Columbia is engaging its robust network of community collaboratives to increase its capacity to deliver Title IV-E prevention services in communities. This community pathway builds on a strong foundation of community infrastructure built over 25 years. The infrastructure was originally designed for families before child welfare system involvement as well as concurrent with or after an investigation or in-home services case. The District of Columbia is also the first jurisdiction to propose an innovative partnership with its Department of Housing and Community Development to create an access point to Title IV-E prevention services for families experiencing housing insecurity without requiring a referral to or involvement with the child welfare agency. This proposal represents an important learning opportunity for establishing cross-agency partnerships to deliver Title IV-E prevention services to Family First target populations.

System Change Component 3: Enhance Accessibility

Promote accessibility of services and supports by building upstream infrastructure and referral pathways, reducing administrative barriers, and deploying strategies to proactively reach families in need. Too often, families do not use the services and supports that are available to them because they are too difficult to access. It is estimated that between 20% and 50% of households do not use public benefit programs for which they are eligible.[107,108,109] This take-up gap is partly attributable to systems and providers failing to reach families—with information, eligibility screens, navigation, and referrals. Moreover, administrative burdens, such as time spent researching programs, filling out forms, waiting to speak to enrollment staff, or engaging in complex eligibility processes deter families from receiving services for which they are eligible. Stigma keeps some families away. These barriers to accessibility compound existing inequities, falling disproportionately on people of color. In order to connect families with supports, public agency staff and providers must assume the burden of making supports and services accessible for families, rather than relying on families to demonstrate their motivation or ability to navigate siloed programs as a prerequisite for support.[110]

Promising Strategies

"Warmlines" or universal navigation infrastructure that all families can access.

While child welfare currently receives referrals through a "hotline," whereby suspected maltreatment is reported, child welfare leaders and diverse human services partners envision a "warmline"—a hub for navigation and referrals that can be accessed outside the child welfare system. Professionals, individuals, and families alike could use these hubs to proactively identify and connect with needed supports and services before a crisis occurs. Because diverse human services agencies, community organizations, national nonprofits and technology companies have successfully engaged in related projects for over a decade, myriad insights and best practices exist to guide the work of child welfare and human services partners embarking on warmline development. While the term "warmline" tends to imply a phone line alone, the core components of such an approach allow for families to access support through multiple integrated mechanisms:

- **Closed-loop service directory and referral platforms,** which families, mandated reporters, peers, and providers access directly online to identify information about services, make referrals, and track their outcomes
- **211** or similar call center
- **Community locations such as family resource centers or navigation hubs** in the neighborhoods, schools, and day care facilities that families know and trust

Through these access points, families can access relatively short, transactional **information and referral** services or more intensive **service navigation**, including coordination and follow-up on service receipt. Ideally, support may be available from peer navigators. Knowing that service linkage is far more likely when families are supported and guided through the process, access to such navigation is essential. Given that the current racial disparity and disproportionality challenges in child welfare begin with the volume of hotline calls, such a strategy has the potential to bring far fewer families of color into child welfare by providing an avenue for their needs to be met early and proactively.

- Minnesota is piloting resource navigation hubs in 12 communities with funding from the federal Pre-School Development Grant B-5. Its goals include making it easier for families to get what they need, increasing access to services, growing community engagement, and supporting community-developed solutions. Preventive strategies focus on addressing local needs through cross-sector collaboration. The hubs are each led by either a nonprofit, a foundation, or a government entity along with partner agencies providing specific supports and services.[111]
- ConnectATX is a collaboration between United Way 211, Findhelp, and the city of Austin, TX to create a seamless system for residents to access supports and services. The call center central to 211 is integrated with the online Findhelp directory, allowing users to access referrals to supports and services online, via chat, or via phone. A bi-directional feed is maintained between the CRM database supporting 211 and the Findhelp service directory, creating a common set of community service information for the jurisdiction. Connect ATX offers three levels of support for callers, ranging from 1- to 3-minute interactions focused on providing specific information about services and support, to more intensive and holistic assessment and service navigation interactions. One feature of the Findhelp platform is Marketplace, technology that allows residents to order social goods and services for direct delivery through the Findhelp platform. For example, navigators supporting the Marketplace application can send groceries or diapers, set up rides, and support fulfillment of social determinants of health (SDOH) benefits under Medicaid or other health insurance plans.[112]

Inter-agency referral pathways with "no wrong door" to access prevention supports. [113,114]

Referral pathways are coordinated across child- and family-serving systems, allowing families to seamlessly access a full array of specialized family services supported by diverse agencies, community organizations and funding streams through a single access point. By reducing the need for families to navigate multiple siloed systems, services and supports can be accessed easily and without delays. While no one jurisdictional example embodies the full potential of a "no wrong door" approach, examples illustrating this approach include the following:

- *Health care*. Prenatal care providers identify pregnant people with SUD and refer for appropriate substance use services.
- *Schools*. School systems partner with behavioral health systems to offer prevention, early intervention, and clinical services to youth and their families—while strengthening referral pathways to community-based behavioral health services that school staff can leverage when they identify additional behavioral healthcare needs.
- *TANF or self-sufficiency*. Diverse health and human services agencies and providers identify families with economic needs and refer seamlessly for needed economic and concrete supports.
- *Home visiting*. Leveraging wide-reaching or "universal" home visiting approaches to support new parents while also identifying and engaging families in more intensive supports across the health and human services spectrum when appropriate.

Holistic screening and assessment strategy

Holistic screening and assessment strategy, centered on family-led identification of strengths as well as economic, social, and parenting needs. In an integrated child and family well-being system, especially one utilizing a "no wrong door" approach, such an assessment could be administered on a voluntary basis at various entry points. This would determine needs and eligibility for appropriate supports available across systems such as Medicaid, SNAP, MEICHV, TANF, Title IV-E prevention services, and community-based resources. Importantly, such assessments must be administered in a manner that is collaborative, family-led, respects family dignity,[115]

empowers families, and uses a strengths-based approach.[116] As described by child abuse prevention expert Deb Daro, when deployed specifically with new parents, such an assessment "would be a tool to enhance parental capacity and would have three goals: reaching all new parents; engaging parents in a conversation about their concerns and their available supports; and helping parents access the supports they need to meet their parenting expectations."[117] While this description centers on new parents, the same could be said for any segment of parents, or all parents.

Some healthcare systems are moving toward such strategies, especially in pediatric primary care settings. These strategies aim to identify not only traditional health needs but also mental and behavioral health and social determinants of health. Such assessments are often administered with a focus on all parents of newborns and young children. Notably, introducing a holistic assessment in a setting that has generally had a narrower focus, such as a pediatric practice that has focused on traditional healthcare, must be done in conjunction with other tools and staff support to ensure that the assessor has the capacity to act on the assessment results. This includes having access to a multidisciplinary care team and to resource and referral technology to identify and make referrals.[118]

- The Center for Urban Child and Family Health at Boston Medical Center utilizes a holistic pediatric primary care approach, the *Pediatric Practice of the Future (POF)*, that addresses medical and psychosocial care needs in an integrated manner. Central to the family's care is a family-led assessment process, whereby goals and needs are identified by the family, including a full range of medical, social, parenting, and financial priorities. Drawing on assessment results, a multidisciplinary care team works with families to address their needs and meet their goals, such as improving behavioral and social-emotional health, increasing financial mobility, and accessing community-based services to address social determinants of health. [119]

Diversion from child welfare

At multiple points throughout the child welfare continuum, children and families are "diverted," or exit the system. Examples include families screened out at the hotline and families with an investigation closing but no subsequent open child welfare case. At these points, too often families leave the system without supports or services, even when they have outstanding economic, health, or social needs that threaten family well-being and stability. Acknowledging the high rates at which many of these families become involved in the child welfare system again, these diversion points represent potentially impactful opportunities to redirect families to other agencies or providers and prevent a return to child welfare.

- Community response programs (CRP) have shown promising results in reducing the risk for subsequent child welfare involvement.[120] These short-term programs voluntarily engage families diverted from CPS with no open case and connect them to community providers who provide economic and concrete supports and case management to help families access resources. Evaluations of CRPs in Wisconsin and Colorado suggest that participation reduces the likelihood of future child welfare involvement.[121, 122, 123] Evaluators of the Wisconsin CRP noted "[t]he use of flexible funds has been identified as an important part of the program in terms of family engagement and immediate stress reduction.[124]"
- Vermont has created a multidimensional economic diversion system to address poverty-related neglect. In this system, families are referred out of more intrusive child welfare interventions to TANF supports, family resource centers, and differential response services.[125, 126]
- In San Diego County, families with a screened-out report who are identified as needing prevention services are referred to San Diego 211, which consists of a 24/7 contact center and online platform providing access to

a comprehensive array of community, health, and disaster support services. San Diego 211 will also connect families to concrete supports and evidence-based programs to reduce the risk of child maltreatment.[127]

- Starting in 2024, the Doris Duke Foundation initiated Opt-in for Families, a national demonstration project across four jurisdictions to test an approach to serving families screened out at the hotline—a key point at which many families are diverted from child welfare, often without services or supports. Through the demonstration, selected jurisdictions are receiving funding, technical assistance, and capacity-building support to design and implement pathways to accessing services and supports, including (but not limited to) material support. Chapin Hall is conducting the formative evaluation of the demonstration project.

Information campaigns and outreach to promote awareness of services and supports.
To increase family engagement and participation in services and supports, states proactively expand outreach efforts to ensure that families are aware of the services and supports in their communities as well as the public benefits for which they are eligible. Effective information campaigns are culturally responsive and available in multiple languages, are easily accessible (for example, through text messaging), and destigmatize seeking support.

- A 2022 Harvard Kennedy School faculty research working paper[128] found that language changes to outreach messages about rental assistance—a highly stigmatized benefit—increased interest in the program by 36% and completion of program applications by 11%, with potentially larger effects for renters of color. The messages aimed to reduce stigma by emphasizing that "it's not your fault," that many residents are struggling to pay their rent, and that the program was intended to help *all* eligible residents get the assistance they deserved.

Reduce administrative burdens for families to access supports.
Administrative burdens are barriers that increase the costs to families—in terms of time, money, and psychological distress and anxiety—to apply for and maintain enrollment in programs. Streamlined and people-centered application materials, simplified income reporting, continuous eligibility, and longer recertification intervals can reduce administrative burdens and increase program participation.[129,130] Gaps in take-up of supports among eligible families stem, in part, from logistical hurdles that can deter participation, especially among the most vulnerable.[131,132,133] States must reduce administrative burdens for families to access services and develop eligibility systems that are people-centered, streamlined, and available online.

- Minnesota launched MNbenefits[134] in 2021 as a mobile-friendly online platform with streamlined applications for nine public benefit programs. This was an effort to significantly reduce time spent on paperwork and increase take-up of multiple programs for eligible residents. It is easy to use and available in English and Spanish.
- First Five South Carolina,[135] the state's recently launched early childhood portal, was developed after receiving extensive feedback from parents and caregivers with lived experience navigating the state's public services for young children. This well-designed and accessible portal helps families to determine whether they are eligible for over 40 public early childhood services, including child care assistance, Head Start, early intervention services, and home visiting programs. It also connects families with applications for additional services and supports for which they may be eligible, including SNAP and Medicaid.

Prioritize meeting basic needs prior to more intensive services [136,137]

Families often need to have their basic needs met before they can fully engage in more intensive services such as family therapy or behavioral health treatment. Indeed, some research suggests that families receiving basic needs support may be more likely to engage, sustain participation, and meet the goals of the prevention and early intervention programs.[138,139] Accordingly, providers may wish to offer concrete supports, such as cash or groceries, up front to promote family readiness for additional services.

- The Center for Family Life is a neighborhood-based social service organization devoted to promoting family and child well-being in Sunset Park, Brooklyn. The Center offers a range of family and community support programs at its central location as well as school-based youth and community programs. Its central building, located in the heart of the Sunset Park community, has four floors, housing a range of services and supports. The first floor, intentionally, houses its Community Services program, which offers support for families in crisis with services that address basic needs—such as a food pantry, benefits access and screening, and immigration legal services. This design recognizes that families may need to meet basic needs and achieve stability before pursuing more intensive services—located on higher floors—such as employment services or family counselling.[140]

System Change Component 4: Family-centered Practice

Build workforce capacity and skills to use practices that center the family, build rapport, and sustain trust. For too long, child welfare and other human services systems have been characterized by coercive, punitive, and directive interactions between the workforce and families. This increases the experience of trauma and sense of mistrust already felt by families, stigmatizes those in need, and inadvertently builds barriers between the family and the individual who is ostensibly intended to help them. Casework practice too often centers on advancing externally driven service plans and expectations, where the family's failure to comply is associated with an implicit or explicit threat of deeper system involvement. As a result, some of the families who need help the most avoid services and resources, further increasing their risk for downstream child welfare involvement. For a voluntary child well-being system to work, families must see the system and the workforce that represents it as supportive and nonthreatening. The following promising strategies would result in a higher rate of engagement in voluntary supports because families will feel comfortable and empowered engaging with the social service workforce. Note that this change component could be particularly effective in conjunction with component #5 below by promoting such practices among a workforce of community members and lived experts.

Promising Strategies

Invest in a prevention practice model.

Prevention practice models articulate the values, principles, skills, competencies, and practice behaviors that can be optimally manifested within all social service professionals, providers, and partners engaging with families within child and family well-being. Prevention practice models translate higher level goals and concepts into tangible activities, actions, and behaviors that professionals and partners demonstrate in their direct practice with children and families to achieve intended outcomes. Child welfare is currently designed as a child protection and foster care system with insufficient investment and focus on prevention and family strengthening, and existing practice models have not yet incorporated an emphasis in this regard. Furthermore, the Family First Prevention Services Act focuses primarily on evidence-based program models without concurrent emphasis on the quality of practice that families experience. A transformation toward a child and family well-being system requires that all system partners adopt an explicit prevention and family strengthening orientation and model of practice, that everyone can identify what it means in their day-to-day work, and that they have the capacity to implement preventive practice with quality and fidelity.

- Washington State Department of Children, Youth, and Families (DCYF) is codesigning a Family Practice Model (FPM) with the goal of preparing and supporting field operations staff by clarifying values-driven practice standards and the commitment to enhancing the professional environment. The FPM includes a cohesive effort to launch guidance on policy, procedure, family practice profiles, workforce development, and quality assurance. The framework highlights the agency's values of inclusion, respect, integrity, compassion, and transparency, and represents a methodical and reliable way to prepare and support staff to adapt to practice changes and promote a best practice standard for case work.[141]

Reimagine assessment tools and processes.

Assessment tools and processes are often designed to identify where children and families may benefit from services, supports, treatment, or skill building. However, the process of engaging in an assessment process may be challenging for families given the perceived stigma associated with needing help. Parents and caregivers may be reluctant to be forthcoming and transparent about areas where they may need help for fear of the potential consequences of sharing their vulnerabilities and support needs, especially with anyone they perceive to be connected with child welfare or other punitive systems. When designing assessment processes and tools within a

child and family well-being system, there is opportunity to craft an approach rooted in family strengths rather than pathology, and to engage families differently in discussions about what help might be most effective. Engaging family members and experts with lived experience in codesigning the assessment development and implementation process is a critical strategy for promoting family engagement and normalizing help-seeking behavior.

- These values and priorities central to Washington State DCYF's FPM (described above) are also being centered in DCYF's pilot of an integrated assessment system that better engages families in the assessment process with the goal of increasing family voice and reducing racial disparities. The integrated assessment system was codesigned by DCYF staff throughout the agency. A Parent Advisory Group and a Parent Ally team will consult the implementation team on the engagement methodology for caseworkers. The new assessment system reflects the values of the FPM and is supported by practice profiles.
- Please see the family led assessment process used by the Center for Urban Child and Family Health at Boston Medical Center, described above under Component 4, *holistic screening and assessment strategy*.

Implement motivational interviewing

Implement motivational interviewing, a collaborative, guiding style of communication characterized by compassion and designed to strengthen personal commitment to change by exploring the person's own reasons for change. Motivational interviewing (MI) creates affirming and transformative service experiences by providing a framework for workers and clinicians to reach, engage, and empower families. As family-serving systems increasingly aim to reach families with voluntary, community-based services, strong engagement will be essential to success.[142] By engaging families to share power, especially families of color, motivational interviewing can play a pivotal role in reversing punitive experiences that have characterized child welfare for too long, while ensuring that families have consistently positive interactions with the social service workforce. With no formal educational requirements, motivational interviewing is often well-suited for a diverse workforce of community members or lived experts.

- Motivational interviewing gained increased traction in child welfare prevention following the passage of Family First. MI is rated at the highest evidentiary level (well-supported) on the Title IV-E Clearinghouse. Although MI is approved as a substance abuse service, several jurisdictions (including California, District of Columbia, Illinois, Washington, Oregon, Kentucky, Michigan, Rhode Island, South Carolina, New Hampshire, and Utah) have obtained approval to use it with families as a mental health or parenting intervention as well. Many of these systems are moving toward implementing MI with a large swath of workforce, reflecting a cross-cutting effort to improve practice and change the way the child welfare and contracted workforces interact with families. For example, New Hampshire is implementing MI within the workforce of its prevention providers responsible for diverse community-based prevention services—including families stepping down from an open child welfare case as well as those referred through other pathways outside of child welfare.[143] Washington, DC is implementing or planning to implement MI among all front line and supervisory child welfare agency staff, contracted community-based providers, and among staff in DC's intake center for families experiencing homelessness (the center is operated by the city's Department of Housing and Community Development).[144]

System Change Component 5: Community-centric Delivery

Shift service delivery to providers grounded in communities that will be served and those with lived expertise. Historically, government funds have been distributed to service providers through procurement and funding mechanisms that favor well-resourced organizations with robust administrative capacity and providers with staff who meet traditional educational and credentialing criteria. This results in a service delivery system that lacks cultural concordance and connection to the communities it serves, compromising its ability to reach families and diminishing its effectiveness. Further, resources and jobs are channeled to those already enmeshed in the dominant power structure. Meanwhile, workforce shortages and high turnover have hampered social service systems nationally, as traditionally credentialled staff seek employment in other roles. A shift toward culturally responsive service arrays and providers that are reflective of local context and needs will be achieved through changing policy to encourage nontraditional provider classes, adjusting procurement practices, and limiting administrative burdens that are prohibitive to many providers. In conjunction with the framework's first foundational condition for change, service design and delivery will be led by served communities.

Promising Strategies

Expand the provider class to engage community members and lived experts with nontraditional professional credentials.

Expand the provider class to engage community members and lived experts with nontraditional professional credentials who live within the communities they serve and whose lived experiences mirror those of their clients. Federal Medicaid policy offers states the flexibility to seek Medicaid reimbursement for services performed by peer support specialists, community health workers, wellness coaches, doulas, and behavioral health coaches. State Medicaid plans and managed care contracts can intentionally invest in this broader array of professionals and in the organizations where they work. This approach promises to center culturally aligned providers with relevant lived experience while investing directly in the communities that Medicaid serves most. While engaging professionals with nontraditional credentials is most clearly codified in Medicaid policy, this practice can be adopted within agencies across the health and human services continuum, including child welfare, as well as providers. This could happen, for example, by adding lived expertise as an optional substitute for formal educational attainment in hiring, or by converting existing government staff lines into roles specifically designed for lived experts.

- In 2022, California expanded access and participation in Medi-Cal through the growth of four new eligible provider classifications: peer specialists, behavioral health coaches, community health outreach workers, and doulas. Although implementation remains underway in California, to date this expansion reflects an unprecedented opportunity for experts with lived experience to be reimbursed for their services.[145]
- New Mexico requires managed care organizations to employ community health workers to assist members in navigating the health and social care systems, especially when addressing health-related social needs. Community health workers possess more local knowledge of community resources and the members' lived experience and are able to provide customized care coordination.

Shift to equitable procurement and contracting practices.

As stated in the Harvard Kennedy School Government Performance Lab's publication *The Journey to a Well-Being-Oriented System,* jurisdictions should focus on "ensuring service arrays are culturally responsive and reflective of local contexts and needs by adjusting procurement practices to include more proximate providers" (p. 18) — including "those that are both physically proximate to the communities they serve and staffed and led by people who have shared lived experiences with their clients."[146] Specific strategies to that end include investing in vendor outreach and unbundling large contracts, as illustrated in the jurisdictional examples below.

- Seeing the need to attract new vendors by offering additional support with the bidding and contract processes, the City of Long Beach, CA, invested in a dedicated vendor outreach coordinator. This staff role was charged with conducting outreach to educate businesses and business associations about solicitations, answer questions, and assist with application and contracting processes. To strengthen and inform these efforts, the City conducted a survey of vendors seeking input on how procurement could be improved to increase competitiveness, equity, and transparency.[147]
- Finding that most of its landscaping contracts went to just two major firms, the city of Phoenix, AZ, "unbundled" its large landscaping contracts to form smaller, local contracts, thus encouraging the city's many smaller and largely Hispanic-owned landscaping companies to bid. Recognizing that smaller vendors would still need additional support to develop successful bids, the city also partnered with a local nonprofit to provide technical assistance to bidders and engaged in new strategies to advertise the opportunity broadly in English and Spanish. Ultimately two contracts were awarded to small local businesses.[148]

Reduce administrative burdens on providers.

Reduce administrative burdens on providers that are required to receive public funds. These burdens include extensive paperwork, data collection and reporting, and unclear business processes that indirectly contribute to the cost of delivering services. Too often, these burdens cause small and community-based providers to opt out of receiving public funds and providing services. Reducing these administrative burdens could also help alleviate the provider shortage currently hampering the mental and behavioral health field.[149]

System Change Component 6: Narrow child protective response.

Building an integrated and holistic family and child well-being system will strengthen access to supports that families need to thrive. However, establishing this alternative, alone, is not sufficient to stem society's over-reliance on child welfare. To create a child well-being system that includes appropriate use of child protective services, systematic efforts must be made to alter the architecture, processes, and behavior that erroneously drive families to the attention of child welfare. The child welfare agency will intervene only when there is a safety risk. All other families must be intentionally directed toward the integrated and holistic family and child well-being system.

Promising Strategies

Modify child neglect statutes

Modifying child neglect statutes that include in their neglect definition families' financial inability to provide for their child without exemptions—so that parents are not penalized for lack of financial means alone. Efforts to change neglect statutes should be undertaken by the child welfare agency in partnership with representatives from the jurisdictional office of the attorney general and partner agencies responsible for the care and protection of children, such as health, human services, and education.

- Kentucky, through its Senate Bill 8 in 2022, narrowed the definition of neglect to situations where a child's welfare is harmed or threatened with harm by a parent due to inadequate care, supervision, food, clothing, shelter, education, or medical care necessary for the child's well-being *when financially able* to provide or when offered financial or other means to do so.[150]
- Washington state changed its removal standard to "only when necessary" to prevent imminent physical harm to child due to abuse or neglect. The existence of community or family poverty, inadequate housing, mental illness, or substance use does not by itself constitute imminent physical harm.[151]

Revise or enhance mandated reporter statutes and training

Revise or enhance mandated reporter statutes and training to promote consistency in decision making and make mandated reporters aware of other options that may be more appropriate and responsive to observed family needs than a call to the child welfare hotline. Akin to addressing child neglect statutes, efforts to change mandated reporting statutes and training must be undertaken with input and buy-in from mandated reporters themselves to ensure that changes will take root.

- In New York, the state Office of Children and Family Services revised its mandated reporter training for professional groups, such as teachers, doctors, and social workers, who are required by state law to report suspected child abuse and neglect. Besides implicit bias training, updates to the required training include information about where to direct a family to community-based programs or resources through the "HEARS" family line.[152]
- California is transitioning from a system of mandated reporting to mandated *supporting* using the Safe & Sound Framework. It is building a system of community-based supports, suggesting standardized training for all mandatory supporters, reviewing hotline data to understand who is calling and why, redesigning the front end of the county's child welfare system, and exploring sustainable funding.

Build capacity and tools for hotline workers

Build capacity and tools for hotline workers to improve their ability to distinguish between poverty and neglect within child welfare referrals. Strategies like these are essential for reducing the number of families that unnecessarily experience the intrusion and trauma of a traditional child welfare response rather than a supportive connection to benefits, services, and community resources that promote family stability and well-being.

- To diagnose whether changes are needed to screening practices, some jurisdictions have undertaken Screening Threshold Analysis (STA), an analytic approach that crosswalks aggregate screening decisions with investigation outcomes. This methodology has been used to date in Indiana, Minnesota, New Zealand, and Ontario, Canada. Results in all of these jurisdictions point, to varying degrees, to the predominance of false positive error and the likely need to make targeted adjustments to screening practices to intervene less often.[153]

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