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Can Public Child Welfare Help to Prevent Child Maltreatment? Promising Findings from Los Angeles

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The American social services system was created at the turn of the last century "out of a simultaneous sense of loss, crisis, and optimism" (Halpern, 1999, p. 3). According to Halpern (1999), the sense of loss was based on longing for the security of family and community life experienced by previous generations when there were strong "informal support systems, clear moral codes, and procedures for enforcing those codes" (p. 3). While this may have reflected an idealized view of pre-industrial society, the very real crises of industrialization and urbanization which brought large numbers of European immigrants and dislocated American farmers to try city life did create socioeconomic shifts that put families, particularly poor families, in harm's way. The sense of optimism came from belief in the knowledge to be gained from the emerging social sciences and hope that the new disciplines of sociology, psychology, and social work would develop effective institutions that would help even the poorest families make their way in a challenging modern world.

Unfortunately, over a century of debates between disciplines with competing theories and leaders with competing beliefs about how social service systems should work does not seem to have clarified pathways to success. This is particularly true in the arena of child welfare where government systems are expected to serve all of the families who come to their attention, despite the families' different histories and needs and the fact that they live in communities with different resources, cultures, and expectations. As a result, the challenges of supporting fragile families, encouraging self-sufficiency, and assuring the safety and well-being of children—the very challenges that early leaders sought to solve by creating social service systems—are still very much with us.

Although there is increasing evidence that particular programs are effective, it has proven much more difficult to re-engineer, re-invent, and reform the overall systems that deal with the many political, financial, and organizational challenges of public child welfare. In addition to the operational demands of providing direct services 24 hours a day, 7 days a week, there are also numerous management challenges, including compliance with policy and legal mandates, budgeting, accounting, information technology, facilities, human resources, and all of the other tasks that support such complex direct service operations. The number and complexity of these tasks makes it perhaps even more difficult to orchestrate and demonstrate the impact of systems change efforts than it is to implement and measure the results of direct service programs (Hargreaves & Paulsell, 2009; Little, 2010).

Overall, public child welfare systems have three key purposes: trying to protect children from child abuse or neglect (child safety), helping

children have a stable family (permanency), and promoting child growth and functioning (child well-being) (United States Department of Health and Human Services, 2010). To help achieve those purposes, four major programs are made available: child protection investigation and services, foster care, adoption, and family-centered services (McCroskey, 2003).

We still draw deeply on the ideas and assumptions of the 19th-century reformers who created three key institutional precursors to our current systems—Societies for the Prevention of Cruelty to Children, Charity Organization Societies, and settlement houses. Three of the core child welfare functions (child protective services, foster care, and adoption) focus on protecting children and placing them in alternative living situations when necessary. The roots of this work can be traced back to the Societies for the Prevention of Cruelty to Children (SPCC), groups that were designed to "rescue" children from abusive families, particularly the poor immigrant and rural families who lived in inner-city tenement houses. SPCC officers were called out to intervene when abuse or maltreatment was suspected. Responding to sometimes horrifying cases of abuse or emotional cruelty (Watkins, 1990), agents used their law enforcement powers to investigate allegations, remove children from the care of abusive parents, persuade judges to take custody of children, and hand them over to "placing out societies" (Folks, 1902). These Societies also worked to prevent maltreatment by threatening parents with arrest and generally trying to scare parents into good behavior. In fact, Homer Folks, a contemporary observer, said: "their greatest beneficence" had probably been "not to the children who have come under their care, but to the vastly larger number whose parents had restrained angry tempers and vicious impulses through fear of 'the Cruelty'" (Folks, 1902, p. 177).

The fourth key child welfare function, family-centered services, sometimes has an uneasy relationship with the other three because it focuses on strengthening families so children can be nurtured and protected at home. These services are essential for the same reason that Charity Organization Societies and settlement houses were important in turn-of-the-century America. Even the most vigilant protective services officers can only remove children from their parents in a small proportion of cases. There have to be alternatives for the vast majority of parents who come to the attention of the public child welfare system because they are poor, overwhelmed, or coping poorly but whose behavior does not threaten their children's safety or cross the line into maltreatment.

Some of these parents may need counseling and home-based services like those pioneered by the Charity Organization Societies, while

others may need the kind of support and concrete assistance provided in early 20th-century American cities by settlement houses. Like the early settlement house residents, many leaders of family support and family strengthening agencies today focus on the socioeconomic conditions of urban life that undermine families. Because of their belief that social and economic conditions were creating problems for families, settlement houses created safe havens where parents could learn new languages and skills, children could be cared for in day nurseries and youth programs, and families could begin to adjust to urban life (Linn, 1935). In contrast, leaders of the Charity Organization Society movement focused largely on individual problems and lack of parenting information that could be resolved inside the family. Mary Richmond and her colleagues created a "scientific" approach to "social investigation," assessing family problems, training "friendly visitors" to advise and counsel parents (primarily mothers), and at the same time providing living examples of how "well-adjusted" American families behaved (Richmond, 1917). Many families, then and now, need both kinds of help.

Our current economic crises have brought many families closer to the brink of being referred to child welfare, and many others have been investigated by children's social workers but allegations of abuse and neglect were not severe enough to warrant a case opening. There are also increasing numbers of caregivers who have taken on responsibility for children when relatives and kin could not manage any longer, parents who need help when their children return from out-of-home care, and youth who emancipate from the foster care system with children of their own. Child welfare isn't, of course, the only system that can or should provide family-centered services and support for all of these families, but it has an important role to play in the community's overall support of families, if only because we need to be able to offer alternatives for the many families who may come to the door of child welfare but whose children can live safely at home. The question is how these agencies can develop effective partnerships with other health and human services systems and with community and faith-based organizations to knit existing services together to better serve families.

This article describes promising findings from the Los Angeles County Prevention Initiative Demonstration Project (PIDP), a systems change approach to developing relationships between public child welfare, allied public agencies, and community-based networks that offer family-centered services, economic assistance, and capacity building to support all kinds of families. The following sections describe the conceptual

underpinnings and unique structure of PIDP, the evaluation methods used to assess results, and promising results measured thus far.

Key Concepts

Over the last few years, neuroscientists have documented the profound effects of early childhood adversity, including the "toxic stress" experienced by maltreated children (Committee on Psychosocial Aspects of Child and Family Health et al., 2012). This explosion of knowledge about the architecture of the developing brain, how early experiences affect long-term development, and how protective factors can be enhanced to strengthen families and promote child development underlines the critical importance of relationships between parents and children in learning and brain development (National Scientific Council on the Developing Child, 2005; National Scientific Council on the Developing Child, 2010; Anda et al., 2006; Horton, 2003). Along with research describing the impact of promising and evidence-based programs, findings on the developing architecture of the brain in early childhood and the possibilities for successful remediation of early disadvantage have encouraged many leaders to underline the urgent need for child welfare to integrate focus on safety and permanency with equal focus on child and family well-being. In April 2012, the Administration for Children and Families released an Information Memorandum to describe its rationale and approach to promoting social and emotional well-being for children and youth, encouraging child welfare agencies to "focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect" (p. 1). The memorandum states:

> . . . [T]here is a growing body of evidence indicating that while ensuring safety and achieving permanency are necessary to well-being, they are not sufficient. Research that has emerged in recent years has suggested that most of the adverse effects of maltreatment are concentrated in behavioral, social, and emotional domains. The problems that children develop in these areas have negative impacts that ripple across the lifespan, limiting children's chances to succeed in school, work, and relationships. (Administration for Children and Families, 2012, p. 2).

PIDP also built on emerging ideas about how to utilize a public health approach to support development of prevention and early intervention systems, bringing resources together to improve behavioral and social-emotional well-being. The National Research Council and

Institute of Medicine's 2009 report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, advances a broad conceptualization based on findings emerging from prevention science. They place services and other strategies along a continuum of health *promotion*, *universal*, *selected,* and *indicated* prevention programs (National Research Council & Institute of Medicine, 2009). *Promotion* refers to strategies designed to encourage or nurture good health. *Universal* is the term applied when a prevention program is helping all populations. *Selective* is applied when focusing only on vulnerable or high-risk populations, and *indicated* is used when prevention programs focus on working with individuals who have early symptoms of a problem or illness. Incorporating this broad public health-oriented framework into child welfare's thinking about prevention requires community-based efforts that extend well beyond the usual purview of the child protective services system, developing ongoing collaboration between public agencies and a broad array of community groups that support and strengthen families at the local level (Schorr & Marchand, 2007, p. ii).

The Los Angeles County Department of Children and Family Services (DCFS) and designers of its prevention initiative used these concepts in their call for community and faith-based organizations experienced in network leadership to work with leaders of DCFS's 18 regional offices to create prevention networks. The call for community-specific networks was based on a community-level change model developed in L.A. that recognizes how social networks and relationship-based community organizing approaches could enhance traditional service delivery approaches that focus on intervention for those classified as being "in need." These prevention networks were designed to reach families living in high-need neighborhoods who had not come in contact with child welfare, as well as families referred to DCFS for whom a case was never opened and families whose children were returning to them after a spell in foster care.

The commissioners, community leaders, advocates, and county department managers who designed the initiative created a forum for almost four years of debate over key premises that could help to bridge, link, and supplement the extensive array of family-centered counseling (Family Preservation) and support services (Family Support and Partnerships for Families[1]) that were already in place in L.A. County.

[1]Family Preservation and Family Support services are offered by community-based organizations under contract with the Department of Children and Family Services. Partnerships for Families is also a community-based program that provides a range of secondary prevention services for families referred to DCFS, but for whom a case is not

They agreed that this initiative should build on existing clinical services but also work to renew and update the settlement house ideals of neighborhood building and community organizing, engaging all family members, and offering concrete support to help families reach self-sufficiency. Collaborative network approaches would be needed to link existing services with a much broader range of supports and activities, making opportunities for engagement, participation, and community action just as visible and accessible to families as were counseling, parent education, and other kinds of individualized services.

The Prevention Initiative Demonstration Project (PIDP) was conceived as a system change effort for five reasons: 1) the Request for Qualifications process called for lead agencies experienced in this kind of work, thus ensuring that the initiative would built on existing community capacity; 2) funds did not primarily pay for delivery of services but supported networks in creating community-based systems and partnerships to leverage existing resources; 3) the initiative was designed to fill gaps in local family service systems by focusing on social connections, economic opportunities, and access to existing community services and resources; 4) DCFS encouraged leaders of local regional offices to build relationships with these community-based networks, planning and problem-solving together to fill gaps in services and supports needed in local communities; and 5) prevention networks were encouraged to work collaboratively with allied public agencies, including county health and human services departments, municipal governments, and local school districts, as well as with community-based organizations and faith-based and grassroots groups.

Implementation

Approved in February 2008 as a demonstration project, PIDP does not take a traditional approach to contracting for specified kinds of services. Rather, it is a community-specific strategy delivered through eight PIDP networks, which work closely with the 18 local DCFS regional offices, which in turn serve L.A. County's eight Service Planning Areas. PIDP planners identified strategies that were essential to strengthen families, improve community safety nets, and prevent child maltreatment for three groups of families—those living in high-risk communities but not involved with DCFS, those being investigated by DCFS Emergency Response workers, and those whose children had open DCFS Family Maintenance

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opened; it is financed by First 5 LA and constitutes a major form of "alternative response" services.

or Family Reunification cases.

Three themes or strands would focus the work of each network: 1) decreasing social isolation; 2) increasing economic stability; and 3) integrating the existing community-based spectrum of services and supports. Each network should devote at least half of its resources to primary prevention, supporting and engaging families, and strengthening social networks so that child abuse/neglect does not occur. Each network should also address secondary prevention, involving parents with unfounded and inconclusive referrals as decision makers in promoting their children's development, learning, and well-being and addressing potential risk factors so that re-referrals for child maltreatment are reduced. And each network should use about 20% of these prevention resources to strengthen the care-giving capacity of parents whose children have open DCFS cases.

PIDP required a relatively modest expenditure of $10 million over the first two years (an annual amount of $5 million per year in L.A. is modest when compared with the annual departmental budget of over $1.8 billion). A total of four years of "demonstration" was originally planned with step-down funding in later years, but findings from the evaluation helped to extend the timeline through 2012-2013 as lessons learned from PIDP are being used to redesign contracting for Promoting Safe and Stable Families/Child Abuse Prevention and Intensive Treatment and other funding streams. The initial investment of $10 million included $3.76 million from the county's Title IV-E Waiver capped reinvestment funds and savings reaped from a previous effort. Specific dollar amounts were designated for each of the eight Service Planning Areas based on the number of child abuse referrals and the total population of families and children living in the area.

Evaluation Methods

The evaluation team included faculty and doctoral students from local universities selected and funded by DCFS and Casey Family Programs. DCFS staff worked closely with the evaluation team, facilitating monthly meetings, providing access to and collecting data, and analyzing data from administrative systems. The evaluation advisory group included at least one liaison from each of the eight PIDP networks, with representatives from DCFS regional offices and support units.

Findings from the first-year descriptive evaluation showed that 89 community agencies and local groups participated in the eight PIDP networks; taken together, these networks served nearly 20,000 people (not an unduplicated count). This included both funded partners as well

as other agencies and groups that made unfunded contributions. "Mapping" of funded network participants showed how agencies used funding from various DCFS contracts, as well as from two key initiatives funded by First 5 LA,[2] to provide a broader range of services to local families. Over half of the funded agencies participating in PIDP networks already received funding through other DCFS contracts or First 5 LA initiatives. About half of the lead agencies relied primarily on DCFS funding, while the other half received funding from both DCFS and First 5 LA. In addition to mapping the key funding streams from these two agencies, evaluators also gathered information on how participating agencies were working to leverage PIDP funding. Examples included additional dollars received from local funders to support PIDP programs, as well as donation of in-kind resources including personnel and office space.

A Network Collaboration Survey, based in part on the Wilder Collaboration Factors Inventory, was developed to assess indicators of effective interagency collaboration. Even in the first year, functioning of these networks was as good as or better than most other social service delivery networks in other parts of the country. Survey findings showed that the agencies involved in these prevention networks had long histories of working in their respective communities; most (87%) had been working for more than 10 years, with 53% working in the community for more than 25 years. First-year study findings showed that all eight PIDP networks worked with local DCFS regional offices to develop plans that addressed local needs, enhanced family protective factors, decreased social isolation, increased economic resources, and connected families to existing resources, activities, and services (McCroskey et al., 2009; McCroskey, Pecora, Franke, Christie, & Lorthridge, in press). These networks had also reached out to a number of other public agencies and were working with their local offices to support families; partners included the Los Angeles County Departments of Public Social Services, Mental Health, Public Health, Probation and Sheriff, as well as the City of Los Angeles, the Los Angeles Unified School District, and other local school districts. Many of the PIDP activities remained the same during subsequent years, but one of the "notable strategies" highlighted in the first-year evaluation report, development of Faith-Based Parent Visitation Centers, was added to the scope of work for all eight networks.

[2]Contracted DCFS programs included Family Preservation, Family Support and Child Abuse Prevention, Intervention and Treatment services. First 5 LA, which is funded by a California tobacco tax ballot proposition, was primarily associated with two initiatives Partnerships for Families and the School Readiness Initiative.

Because PIDP was a multifaceted strategy, stakeholders had many questions about whether and how it worked, which local approaches worked best, and whether outcomes could be achieved using different strategies. In order to respond to an array of questions—while optimizing available data and minimizing the need for new data collection—the team used five key themes and sets of questions to guide the evaluation process.

1. *Protective factors*. Did participation in PIDP increase the protective factors[3] known to strengthen families and prevent child maltreatment? If so, were improvements in protective factors associated with decreased need for child welfare intervention or different kinds of intervention?

2. *DCFS case flow*. Overall, for each SPA and each regional office, what were the trends in terms of referrals, substantiation rates, new cases coming into the DCFS system, and children removed into out-of-home care?

3. *Activities*. How many families participated in PIDP activities? What was known about the characteristics of participants and how they were "touched" by the initiative? This included families who had not had any contact with DCFS prior to their involvement with the prevention initiative.

4. *Involvement of DCFS families*. To what extent did children and families already involved with DCFS participate in prevention activities? What factors help to explain different patterns of involvement?

5. *Impact on case openings and reunification*. Did PIDP affect the likelihood that families in three specific high-risk communities would move from a hotline referral status to an open case? Did it affect the likelihood of family reunification for cases in two other communities?

One of the first tasks of the evaluation team was to determine whether it was feasible to integrate data from multiple sources to clarify retrospective results for identifiable families in key communities during the initial project year 2008-2009. Although families served by PIDP in 2008-2009 might not be identifiable in every community, there were two

[3]Defined and championed by the Center for the Study of Social Policy's Strengthening Families Initiative, protective factors describe a strengths-based approach that has been adopted by many at the federal, state, and local levels to guide strengths-based work in child welfare (Center for the Study of Social Policy, 2012). According to the Child Welfare Information Gateway (2012), "Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities that, when present, increase the health and well-being of children and families."

advantages in focusing on 2008-2009 where possible—attitudes toward allowing families known to DCFS to participate in preventive services were arguably most open in this time period, and longer-term follow-up was possible.

To better understand the impact of prevention efforts, an instrument designed to measure protective factors was developed by Dr. Franke in collaboration with agency staff, families, and community members who participated in Neighborhood Action Councils. Relationship-based organizing strategies that led to creation of these local councils were used as a keystone strategy by PIDP networks in four of the eight Service Planning Areas, building on previous work by one of the lead agencies.[4] The Relationship-Based Organizing Protective Factors Survey includes 72 items, with four factors designed to measure protective factors: Social Support, Personal Empowerment, Economic Stability/Economic Optimism, and Quality of Life. An additional single item measures quality of life. Also included are five factors specific to families with children: Immediate and Extended Family Support, Professional Support, Personal Non-Family Support, Successful Parenting, and Parenting Challenges. Both survey versions were translated into Spanish, and each 72-item section (retrospective and current) took approximately 45 minutes to complete.

Due to regional differences in focus and implementation, analysis of outcomes for DCFS families varied across the five regions; five communities were the focus of particular attention. In three regions, the focus was on referrals of Emergency Response cases during the investigation stage, while in two additional communities the focus was on family reunification for children already in out-of-home care. The evaluation team discussed data needs and plans with DCFS deputy directors, regional administrators, and the eight PIDP networks in order to develop a focused but practical analysis plan. Staff from each regional office and from the local PIDP networks participated in sample selection and identification of cases for the specific category of families served in their area. DCFS staff assisted in organizing the data, including linking with appropriate staff at regional offices. In order to assure confidentiality, analyses were completed by staff in the DCFS Bureau of Information Services.

Study Limitations

Limitations included the fact that the parent survey was administered in different ways at different points in time in different communities. As a

[4]South Bay Center for Counseling, www.sbaycenter.com

result, there were some parents who did not complete the protective factors survey for a second time, so there were no data on whether or how their functioning had improved. Also, while the special community analysis of DCFS outcome data did rely on comparison families who were randomly chosen from matched groups of similar local families who did not receive PIDP services, the evaluation design did not allow for random assignment of families at the start of the project to PIDP and comparison group conditions.

Promising Results

The reach of PIDP during its second full year of operation, 2009-2010, was about the same as in 2008-2009. An unduplicated count showed that the eight PIDP networks served 17,965 people; 13% (n=2,391) were individuals involved with DCFS—either during the investigation stage or after a child abuse case had been opened.

Improvements in Protective Factors

Data collected from the survey and focus groups held in all eight Service Planning Areas (December 2009 through April 2010) highlighted the benefits that parents and youth reported receiving through their participation in local Neighborhood Action Councils and other parent and family involvement activities. The survey was administered to participants in all Service Planning Areas, but methods were adapted to meet local needs. In some areas, a retrospective version of the survey was administered; respondents reported current ratings on survey items and six-month retrospective ratings on the same set of items. In another version of the survey, administered to families in three other areas, respondents reported only current ratings. Because of limited time and research capacity at some agencies, only a nonrandom subsample of respondents completed the retrospective version of the survey. Results from the survey were calculated for three groups: 1) 355 PIDP survey respondents who participated in Neighborhood Action Councils (NACs) in four areas; 2) other PIDP NAC participants plus an additional 183 survey respondents who participated in other social networking strategies in four other areas (n=538); and 3) 1,001 survey respondents participating in additional NACs not sponsored by PIDP.

Parents and youth who participated in NACs (as well as the smaller number who participated in other kinds of social networks) reported a pattern of benefits including greater involvement in their community, more desire to engage in community activities, and decreased feelings of loneliness or isolation. Participants reported a significant improvement

across three points in time for five factors and a quality of life item. Significant changes were found for three additional factors between two time points. The effect sizes, while statistically significant, were in the small range for all areas of functioning. Responses suggested that the impact of this strategy on protective factors was most evident during the first four to six months of participation, and then benefits stabilized. Given the nature of the relationship-based community organizing model used by the NACs, it would be expected that perceived improvements in the protective factors measured would be evident as the groups form and become cohesive and as participants develop relationships with each other. Similarly, it would be likely that once the group has attained a moderate to high level of cohesion (likely to occur within the first six months of group formation), changes in perceived levels of support from group participation would stabilize.

This pattern of benefits reported by participating families is particularly important because such protective factors have been linked to long-term strengthening of families (Center for the Study of Social Policy, 2012) and significant reductions in substantiated reports of child maltreatment (Reynolds, Mathieson, & Topitzes, 2009; Reynolds & Robertson, 2003).

Economic Development and Family Self-Sufficiency

PIDP networks also work to improve family economic conditions, weaving financial and economic development strategies into their approaches to preventing child maltreatment. The networks used a variety of activities including employment preparation and placement, summer youth jobs, support for small business development, classes on financial literacy, and access to GED and employment training classes. The wide variety of activities reflects different focuses, including creating access to capital by utilizing partnerships to generate revenue for residents and neighborhoods, increasing employability, decreasing roadblocks to employment, and increasing financial literacy.

Findings show that these family economic empowerment strategies produced positive results in terms of employment training, job placement, and income supplements across the county. Some families had access to training in financial literacy, budgeting, banking, and credit management; others had access to personal coaching on achieving educational goals, preparing for employment, and developing small businesses. For example, between 2008-2010, the Ask, Seek, Knock (ASK) Family Resource Centers (serving Compton, Watts, and the entire South County area) trained and placed nearly 300 local residents in the workforce. At

the request of local residents, the network also provided access to pro bono legal assistance for over 1,000 participants; these services helped parents navigate the court system, expunge criminal records, and address a broad range of citizenship, housing, adoption, and other legal issues.

Most PIDP networks worked to expand access to Earned Income Tax Credits (EITC) by setting up local tax centers or working through established Volunteer Income Tax Assistance (VITA) sites. PIDP networks in four of the eight areas joined forces to create the Greater LA Economic Alliance, which provided free income tax preparation for individuals with a maximum gross annual income of $50,000, free workshops on EITC and childcare tax credits, small business tax preparation, and preparation of applications for Individual Taxpayer Identification Numbers. More than $4.4 million in tax credits were filed for and received by residents in these areas in 2009-2010 alone. The refunds provided an average refund of $1,062 for participating families. Networks that worked with existing VITA sites engaged an additional 4,315 individuals. About 77% of those surveyed indicated that they expected a refund; the majority were Latino or African-American, and over 55% reported earning less than $20,000 annually.

Changes in Re-Referrals and Reunification for DCFS Families

Evaluators took an individualized approach to analyzing DCFS data from the Child Welfare Services/Case Management System (CWS/CMS) in different communities, reflecting the local goals and approaches of the networks and their partner DCFS regional offices. Five communities were selected for analysis, representing the five Service Planning Areas where PIDP networks served the largest number of DCFS families. Working with local DCFS and network leaders, evaluators identified the most appropriate samples and methods for establishing comparison groups using random sampling. Evaluators worked with administrators in local offices to identify people served by the PIDP network and to describe referral criteria accurately so that DCFS staff could randomly select appropriate CWS/CMS records for comparison. Results for PIDP families were compared with those of randomly selected local comparison groups designed to match program conditions and referral criteria. Statistical significance was determined using two-sample test of proportions. In all cases, an alpha level at .05, one-tailed, was employed. Findings for the five communities were as follows.

Lancaster (SPA 1). Analysis focused on re-referrals to the DCFS Hotline for 40 families served by PIDP in comparison with a group of 70 other Lancaster families receiving the same kind of DCFS Emergency

Response services during the same time period. The comparison group was randomly selected and matched on referral year and disposition of allegations, but evaluators were unable to match families on their specific need for concrete supports, a primary reason for referral to the SPA 1 PIDP network. Analysis focused on subsequent re-referrals during the program period (between June 2008 and July 2010). While 23% (n=9) of PIDP families were re-referred to DCFS during the study period versus 31% (n=22) of the comparison group, this difference was not statistically significant (z=1.00). For the purposes of this analysis, a "re-referral" to DCFS meant any call to the hotline deemed serious enough to require an in-person visit; thus, hotline calls that were "evaluated out" or eliminated from follow-up were not included.

Although the numbers were quite small, the percentage of substantiated dispositions for subsequent allegations was higher for the PIDP group than for comparison families: 56% (n=5) of the PIDP families and 27% (n=6) of the comparison group. This difference was not statistically significant (z=2.23). This suggests that, having tried a supportive prevention-oriented approach, Children's Social Workers (CSWs) in the DCFS office may have weighed subsequent allegations more strongly, received more information from the PIDP network, had additional information on family circumstances that went well beyond the concrete needs presented by the family initially, or identified more challenging problems through re-referral.

San Fernando Valley (SPA 2). Analysis of CWS/CMS data in this area focused on 38 DCFS families receiving DCFS Emergency Response (ER) services; these families were also served by PIDP in three target zip code communities selected by the DCFS regional offices.[5] Managers in the three DCFS offices serving this area suggested that CSWs tended to refer families with less serious circumstances as well as very seriously troubled ER families because they trusted that the PIDP network could deal effectively with the full range of family problems. The network lead agency was known as going "above and beyond" to assure that families received appropriate services. The subgroup that was ultimately included in this analysis included 38 families; screening by DCFS administrators excluded 15 families with extremely serious problems from the original group of 53 families identified as having been referred to PIDP. The PIDP families were being investigated by DCFS at the time of referral and had at least one prior referral within 12 months; they did not have serious and sustained problems (e.g., histories of domestic violence or violent criminal

[5]Pacoima, North Hills, and Van Nuys

charges) and thus might benefit from approaches that could prevent re-referral. A comparison group of 100 families, selected by thirds from each of the target zip codes, included a similar group of families under investigation by DCFS with at least one prior referral within 12 months. Findings showed no statistical difference between PIDP and comparison group families (z=.533). Both groups had similar proportions of re-referral to DCFS—32% of PIDP families (n=12) versus 27% of the comparison group (n=27).

Similarly, there was no significant difference in substantiation for the very small group of families who had subsequent allegations. One third (33%, 4 out of 12) of subsequent allegations were substantiated for the PIDP group versus 15% (4 out of 27) for the comparison group (z=1.32). DCFS opened cases on all four of the substantiated referrals from the PIDP group but only one of the substantiated referrals in the comparison group, again suggesting that CSWs may have reacted differently when families had been served by PIDP. Managers in the three offices suggested that whether subsequent referrals were from mandated reporters in the PIDP network or from others outside the network, CSWs tended to turn to PIDP staff for further information when another referral came in, since they trusted their observations and the quality of services provided and since they knew that network agencies would continue to be involved in the family's life. This suggests that the prevention approach taken in SPA 2 may enhance the safety of children because "another set of eyes" is available to support caseworkers dealing with repeat referrals of families in high-need areas.

San Gabriel Valley (SPA 3). Analysis of CWS/CMS data in Pomona and El Monte focused on reunification and case closure for a total of 110 DCFS children whose families received PIDP services; this included 67 DCFS children who were in out-of-home placement and 43 DCFS children who received Family Maintenance services from DCFS while remaining at home. Statistically significant differences were found for the Family Reunification group but not for the Family Maintenance group. This network used a case management model co-developed with DCFS to address the disproportionate numbers of African American and Latino families coming to its attention. The group identified specific neighborhoods with high numbers of DCFS referrals and open cases and disproportional representation of families of color. The model includes a four-person team with a case manager, a mental health clinician, a parent advocate (a life-trained paraprofessional who has successfully navigated the DCFS system), and a cultural broker (a culturally and linguistically appropriate person who assists families in navigating the protective

services system). In addition, the cultural brokers were available to attend Team Decision Making meetings when CSWs believed they could be helpful; in 2009-2010, the SPA 3 PIDP network reported that PIDP cultural brokers attended 200 of these meetings in the El Monte (n=86) and Pomona (n=114) regional offices. The network also referred families to social networking groups provided by Parents Anonymous and a broad range of services provided by other network partners. The randomly selected comparison group from the same time frame and geographic areas included 200 cases, equally divided between Family Maintenance and Family Reunification cases.

Findings show that a significantly higher percent of PIDP children left the foster care system; 81% (n=54) of PIDP children left care versus 58% (n=58) of the comparison group ($p<.05$, $Z=2.93$). A higher percentage of PIDP children experienced positive "permanency exits" of reunification, adoption or guardianship than those in the comparison group—67% (n=45) of PIDP children versus 54% of comparison cases (n=54)—but this difference was not statistically significant ($z=1.70$). The difference between case closures for PIDP children with Family Maintenance cases (91%, n=39) versus the comparison group (80%, n=80) was not statistically significant ($z=1.57$). More information on the specific approach used in this region is available in a 2012 paper by Lorthridge, McCroskey, Pecora, Chambers, and Fatemi.

Compton (SPA 6). Analysis in South Los Angeles focused on outcomes for 180 DCFS families served by the Compton Ask Seek Knock (ASK) Center, one of four such family resource centers developed by the network. Most of the families referred by DCFS were being investigated by Emergency Response social workers (n=130), while an additional 50 families had children with open Family Maintenance or Family Reunification cases. Between them, the 50 families had 120 children with open cases, including 31 cases where children were in out-of-home placement. The ASK Centers are open to all families regardless of income, residency, or DCFS status, providing a safe place where families can work with trusted "navigators" to find resources from a database of over 1500 local resources. ASK Centers also provide education, employment training, pro bono legal services, and a wide range of social networking opportunities.

In the first analysis, the 130 Emergency Response families included 109 new referrals and 21 re-referrals on existing open cases. A comparison group of 150 Compton families was randomly selected to match these proportions weighted by referral year and allegation disposition. Results show that families receiving PIDP services were

significantly less likely to be re-referred to DCFS compared with the randomly selected comparison group—12% (n=15) of PIDP families versus 23% (n=34) of the comparison group. This difference was statistically significant ($p<.05$, $Z=2.22$).

In the second analysis, the PIDP group of 31 foster children with open cases whose families took advantage of ASK Centers were compared with a randomly selected group of 50 similar foster children from Compton. Findings showed no significant differences between the two groups in the percentage of children who exited from foster care during the study period—52% (n=16) of the PIDP group versus 48% (n=24) of the comparison group ($z=.316$). However, there was a significant difference between the PIDP children and those in the comparison group—100% of the PIDP children left foster care for "permanency exits" of reunification, adoption, or guardianship, compared with 83% of the comparison group ($p<.05$, $Z=2.11$).

Torrance and Lakewood (SPAs 7 & 8). Analysis focused on reunification for families using the two faith-based Family Visitation Centers established through collaboration between DCFS, PIDP, and two local churches. Although the primary focus of the PIDP network in this area is on relationship-based community organizing as described earlier, the networks responded to the request of local DCFS regional administrators to help them develop a visitation model that would involve local faith-based congregations in supervising and monitoring visits between parents and children. Since this network helped to develop faith-based Family Visitation Centers, a model of particular interest to DCFS, analysis focused on records of Family Reunification cases referred by the two DCFS offices in the area, a total sample of 79 cases. The randomly selected comparison group of 100 cases was matched on geography, children in out-of-home foster care, families having had at least one supervised visit in a DCFS office, and worker indication of need for monitored family visits (there were long waiting lists for the faith-based Family Visitation Centers during this time frame).

Findings showed significant differences between children served by the faith-based Family Visitation Centers (n=79) and the comparison group (n=100). Seventy-one percent of the PIDP sample (n=56) left foster care during the study period versus 55% (n=55) of the comparison group. For the PIDP group, 69% (n=55) experienced "permanency exits," 1% (n=1) had a less positive exit, and 29% (n= 23) were still in care. For the comparison group, 50% (n=50) experienced "permanency exits," 5% (n=5) had less positive exits, and 45% (n= 45) were still in care. The PIDP children were significantly more likely to leave the foster care system

($p<.05$, $Z=2.04$) and more likely to have positive "permanency exits" ($p<.05$, $Z=2.41$). Children whose families were unable to take advantage of the Family Visitation Centers were significantly less likely to exit the foster care system ($p<.05$, $Z=2.04$).

This pattern of positive findings across outcome areas and across communities supported positive perceptions gained through informal observations of PIDP (Edgar, 2009). Evaluation findings helped to persuade the L.A. County Board of Supervisors and the public child welfare agency to continue support for PIDP. The demonstration project, which was initially approved for four years, has been extended more than six (at least through June 30, 2013, and the lessons learned in this effort are being used to redesign contracts for a broad range of community-based services supported by DCFS.

Implications and Conclusions

The pattern of positive evaluation findings also document promising directions for community-based partnerships that include public child welfare as one of the key players in developing an effective continuum of health *promotion*, *universal*, *selected,* and *indicated* prevention services. These findings support the vision initially embraced by Los Angeles County and the PIDP planning group—that child welfare could play an important role, working collaboratively with other public agencies and local funders to support community-level systems change and developing ongoing partnership networks, including community-based agencies and faith-based and grassroots groups working with families and youth to prevent child abuse and neglect. Implementation of PIDP required leaders in L.A. County government to step outside of their comfort zones, looking beyond traditional methods of delivering services to active clients. They invested in community-based networks that could play multiple roles in poor communities – improving capacity and supports for all families as well as serving a broad range of families already known to the child welfare system. These leaders deserve substantial credit for going beyond service as usual, encouraging new ideas about preventing child maltreatment, and working with leading community organizations to invest in communities.

PIDP differs from many prevention-oriented programs supported by public child welfare agencies in that it does not limit family-centered services to a specific counseling, parent education, or home visiting intervention approach that focuses primarily on alleviating risks or resolving problems within the family. In fact, this prevention initiative was not designed to fund direct service delivery, but instead PIDP dollars

represent "glue money" that can knit together funding from multiple sources, thereby increasing access to the full range of existing services, supports, and activities that could benefit families and children. This framework allowed experienced community based organization leaders to use resources more creatively, spanning funding silos that limit flexibility both within their own agencies (an often unforeseen result of contracts from multiple funding streams), as well as creating networks and partnerships with other organizations that serve the same communities. In the long run, it makes more sense to organize the capacity that already exists in local communities rather than duplicating capacity by assembling a wide range of services under a single agency umbrella, but categorical funding streams seldom consider the long run.

By not limiting access to the full range of activities available based on a family's status with the child protective services system, PIDP was also able to call on a much broader range of community stakeholders. How often do we think about banks, arts groups, employers, churches, and libraries as active participants in preventing child abuse? Yet these and many other "unlikely suspects" were and are members of L.A.'s prevention networks.[6] The breadth of the PIDP vision means that the networks cast a broad net to search for potential network members. Stakeholders were not limited to community-based organizations, and perhaps most importantly, family interests were not assumed to be limited to alleviating risks or problems. There was room to explore all of the protective factors that might help families nurture and support their children. Focusing on all five protective factors—parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and children's social and emotional development—broadens participation to almost anyone interested in families and communities. And it also means that child and family well-being is a core element of the mission, as important as protecting child safety and assuring permanency.

When a broad community-level goal such as preventing child abuse and neglect is the desired result, the experience of the PIDP networks suggests that we need to revisit the example of the settlement houses,

[6]Examples of participants in the eight PIDP networks include: Kinder Music, Antelope Valley Reentry Coalition, Unusual Suspects Theatre Company, Clearpoint Financial Solutions, U. S. Census, Los Angeles County Commission on Human Relations, Westland Mobile Home Park Community Center, Community Financial Resources Center, Big Time Telephone Services, Southeast and Quantum Community Development Corporations, and the Southern California Indian Center. For more information and profiles of PIDP networks, see Casey Family Programs (2010), volume two.

supplementing our reliance on case management, investigation, and delivery of clinical intervention services with community-based networks, family strengthening, support, and concrete assistance in times of need (Bowie, 2011; Schorr & Marchand, 2007). Just as the thinking of reformers at the beginning of the twentieth century was shaped by social and economic turmoil, our thinking today needs to be based on understanding that global economic patterns affect the daily lives of families in every community, making it even harder to nurture and care for our families. PIDP demonstrates that public child welfare agencies can make a significant contribution to preventing child abuse and neglect, as well as preventing recurrence of maltreatment for families who are already involved with the child welfare system, but our vision of the possibilities for family-centered services needs to incorporate our roots in both the clinical services provided by the Charity Organization Societies *and* the support for families provided by the settlement houses. PIDP offers a promising model for how the two traditions can be combined into a new approach to family-centered services for the 21st century.

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