

A Shift in Perspective: A Universal Approach to Child Protection

Deborah Daro

Summary

In the United States, two approaches have developed to exercise collective influence on how parents raise their children. One is mandatory public intervention in families who have placed their children at risk, exemplified by the child welfare system. The other is voluntary offers of assistance, for example, child abuse prevention services that place responsibility on parents to determine whether they'll accept the advice they receive and change their behavior.

In this article, Deborah Daro traces a shift in emphasis from a Progressive-Era policy that offered common supports to all new parents to a more bifurcated prevention system that emphasizes public investments primarily for those parents and children at highest risk. Moreover, she writes, for the past 50 years, voluntary and mandatory parental assistance have operated independently, with minimal shared agenda setting and planning. She contrasts this to the health care system, where early assessment and diagnosis mean that people receive a continuum of care, based on their level of need. Early medical treatment isn't viewed as intrusive; it's seen as an important first step in protecting health and avoiding more complex and costly therapy.

Unfortunately, Daro argues, the policy response to parental shortcomings isn't comparable. There's no adequate early assessment when people become parents, and child welfare agencies typically offer assistance only after a child is harmed. She suggests that the time is right for a universal approach that reaches out to all new parents, offering each family a level of assistance commensurate with their needs. Ideally, she writes, "Seeking out and accepting formal public services to help meet parenting demands should be as acceptable as using preventive health care."

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Shared child-rearing standards are rare, particularly in a multicultural society that values the rights of parents to determine their child's best interests. In setting common standards, policy makers struggle to balance three aspirational, but often competing, values—child safety, healthy child development, and parental autonomy. Mandating public schooling exemplifies a generally accepted, shared child-rearing standard. Mandating specific parental techniques, on the other hand, is far more controversial and subject to reasonable legal and normative disagreements.¹ Even when a society can agree on what it wants for the next generation, government's role in ensuring these goals veers between helping parents to do the right thing and assuming parental responsibilities if they do not.

Given these societal and legal disagreements, two pathways have developed to exercise collective influence on how parents raise their children: mandatory public intrusion and voluntary offers of assistance. The public child welfare system illustrates the first approach. This system limits public intervention to parents who have harmed their children or who have placed their children at risk. Once government identifies these at-risk children, it subjects parents to a set of rules and statutes that can determine their future relationship with their children. By contrast, child abuse prevention services are voluntary and place responsibility on parents to determine when they will allow others into their private sphere, and whether they'll accept the advice being given and ultimately change their behavior. For the past 50 years, these two systems have operated independently, with minimal shared agenda setting and planning. Policy makers have paid little attention to the continuum of risk

and variability among families' opportunities for adequate support and early intervention. Disparities in service access, often shaped by race and class, mean that a disproportionate number of minority and poor families receive distinctly fewer and often more punitive service options.

This divide between mandated and voluntary parental assistance stands in sharp contrast to the way other systems, particularly health and education, carry out their mission. For example, when a patient is diagnosed with precancerous cells, she is neither immediately offered chemotherapy nor told to go away until the disease reaches Stage IV cancer. Rather, the patient is offered an intervention appropriate for her condition. Early medical treatment isn't viewed as intrusive; it's seen as an important first step in protecting her health and avoiding more complex and costly therapy. Unfortunately, the policy response to parental shortcomings is not comparable. Our public response lacks an adequate early assessment when people become parents, and we often offer the appropriate level of assistance only after a parent fails to meet expectations or a child is harmed.

The Family First Prevention and Services Act (FFPSA), coupled with a significant expansion of prevention services focusing on new parents, represents an opportunity to build an alternative approach that can bridge these two systems. Such an approach is not entirely novel. Integrated treatment and prevention is not only a hallmark of our current approach to health and education, but also has roots in how we approached supporting new parents in the Progressive Era. Rather than operating in isolation, child welfare and targeted prevention programs have an opportunity to reignite

the spirit of universal service delivery that marked maternal and child health reforms in the early twentieth century. Creating a shared understanding that treatment and prevention are mutually reinforcing would move us closer to a more equitable and just balance among the goals of child safety, child development, and parental autonomy.

The Progressive Policy Response

In the late nineteenth and early twentieth centuries, state and local coffers supported most public investments in social services, health care, and education, often working closely with local charitable and religious associations.² The Children's Bureau, established in 1912, represented a new federal presence in child care and family support, operating new programs and underwriting research on the nation's infant mortality rate.³ This research examined the primary causes of infant mortality and explored why the US rate exceeded the rate observed in other advanced economies.⁴ It suggested, among other things, that infant mortality could be reduced not just by changing the public service infrastructure and enhancing environmental safety, but also by providing information and health services to pregnant women and new parents, particularly those living in rural areas.

The Sheppard-Towner Act

The Sheppard-Towner Act of 1921 created the first federal investment in explicitly promoting prenatal and infant care education and health services for families.⁵ This policy generated significant debate. Opponents included the American Medical Association, which defined the effort as "an imported socialist scheme unsuited to our form of government." Some legislators viewed the act as part of a Bolshevik conspiracy. Others

feared that it represented an attempt to remove children from the care of their parents by "turning control of the mothers of the land over to a few single ladies holding Government jobs in Washington."⁶ But with women now having the right to vote and elected officials wondering how this new voting block might influence political alignments, the bill passed easily. It gave states incentives to establish a Bureau of Maternal and Child Hygiene that would manage the funds and institutionalize the public response for maternal and child health.

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The act was structured to be universal. Sheppard-Towner didn't require beneficiaries to be both "needy and deserving." Although it emphasized expanding services in rural areas and small towns, it didn't establish eligibility requirements for individual participants. Qualified recipients included any pregnant women or new parents who needed information or assistance for themselves or their newborns. Participants responded positively to this universal offer of assistance and, in the words of one author, often expressed pride in "raising their babies in the government way."⁷

The Sheppard-Towner Act authorized modest investments: \$1.48 million in its first fiscal year and \$1.23 million per year

for the next five years (\$19.4 and \$17 million, respectively, in 2018 dollars). Of this sum, each state received \$5,000 (\$70,000 in 2018 dollars) with the option to get an additional \$5,000 if the state generated matching funds. All but three states—Massachusetts, Connecticut, and Illinois—eventually adopted the program.

The initiative supported nurse home visiting; midwifery education and professional development programs; construction and staffing of public health centers; removal of environmental hazards; prenatal care and child health care conferences; and informational letters to pregnant women regarding “scientific” or “modern motherhood methods” to improve pregnancy outcomes and guide early infant care.⁸ All direct services were voluntary. The law expressly prohibited providers from entering a home uninvited or to take charge of a child without legal consent.

Although the initiative ended in 1929, detailed information provided by the states to federal monitors suggests that Sheppard-Towner yielded notable results. In seven years, local health officials held 183,252 health conferences and constructed 2,978 permanent prenatal health care centers, primarily in rural areas that historically lacked such services. State personnel distributed over 22 million instructional pamphlets and prenatal letters to pregnant women and new parents, many of whom embraced the guidelines in caring for their infants. In the initiative’s final four years, more than four million infants and 700,000 expectant mothers were reached by some form of public health work conducted under the Sheppard-Towner Act.⁹

Impacts on Infant Mortality Rates

Between the act’s passage in 1921 and its expiration in 1929 (when Congress failed to reauthorize it), the overall US infant mortality

rate fell from 76.2 to 67.6 per 1,000, an 11 percent drop.¹⁰ Proponents of the bill claimed this finding as empirical evidence that the act’s investments produced the desired outcome. Opponents posited that the decline simply reflected a trend that began earlier. Indeed, the infant mortality rate had dropped 35 percent between 1915 and 1921, and it fell another 26 percent in the ten years immediately following Sheppard-Towner’s termination.¹¹

Inconsistent record keeping and the rudimentary nature of social science research at the time makes it hard to determine the act’s impacts. Massive infrastructure improvements in sanitation and water quality, among other factors, had raised safety standards and eliminated key factors that contributed to early child deaths. Recently, two economists at Rutgers University examined state and federal archival records on how states invested their Sheppard-Towner funds alongside aggregate data on state level infant mortality rates. To isolate the potential impact of Sheppard-Towner, the authors controlled for prior state trends in infant mortality and any other so-called *fixed effects* that might have influenced trends at both the national and individual state levels. Keeping in mind that the data set and the study’s methodology had notable limitations (uneven documentation of other state-initiated public health investments and an underreporting of infant mortality rates among blacks, for example), the authors estimated that the Sheppard-Towner Act may have accounted for 9 to 21 percent of the decline in individual state infant-mortality rates, primarily due to its impacts on white infant mortality.¹²

The study found, not surprisingly, that state investments in less patient-focused interventions, such as conferences, health fairs, and midwifery education, had less impact on a state’s overall infant mortality

rate than did investments in nurse home visiting or the expansion of health clinics. Material distributed at public fairs or left in clinics for women to take home had less impact than child care information mailed directly to new mothers. States that invested in building health clinics where pregnant women and new mothers could receive follow-up services, as opposed to states that did not invest in permanent infrastructure, saw more sustained reductions in infant mortality.

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Implications for Current Policy

The Sheppard-Towner Act's structure and implementation offers three important cautionary tales for those crafting today's parent support policies. First, the legislation's success hinged on local ownership of the idea. Infrastructure improvements and matching state investments yielded better outcomes over time. Though critics called the act an attempt to socialize medicine and create a federal wedge into the private family, the legislation contributed to common standards around child rearing by offering services to all pregnant women and new parents, regardless of income or race. And by educating the public about the value of prenatal care and various child-care techniques, it articulated a shared, common understanding among new mothers on how to help each other in times of stress.

Second, the legislation demanded state accountability, including documentation on

the types and number of activities provided and the number of families reached. Perhaps reflecting the emphasis on scientific charity that was common during this period, agency directors accounted for how they invested funds, who the funds served, and what impacts the funds had on targeted outcomes. It's hard to know the consistency and quality of these data, but this early emphasis on linking efforts to outcomes established an important precedent for documenting the level of effort and making a case for future investments.

Third, the program underscored that it's important to use a combination of strategies. Public awareness efforts and education, infrastructure and professional development, and participant-level interventions all played a role. Success didn't hinge on a single strategy or silver bullet. Most important, all pregnant woman and new parents could access services and find appropriate follow-up care if they needed it. In this respect, the Sheppard-Towner Act served as a conduit for changing standards of care and expanding local service capacity.

Sadly, the universal, unqualified nature of helping all parents died with the Sheppard-Towner Act itself. Scholars have noted that the act was a bridge between the Progressive Era reforms and the New Deal.¹³ Indeed, the Social Security Act of 1935 significantly expanded federal investments in maternal and infant health and wellbeing, as well as support for families unable to care for their children. Over 80 percent of the new funding targeted services for "crippled children" (11 percent) and nonmonetary aid and social services to "dependent children" (72 percent). Though it reached a larger proportion of poor children, this policy eliminated any notion that children have

universal needs and parents face universal challenges. The assumption that only poor or disadvantaged families would require public assistance became standard.

The Modern Child Welfare System

C. Henry Kempe and colleagues' 1960s research established a clear and compelling need for a formal child protection system.¹⁴ They examined hospital emergency room X-rays in 70 hospitals and surveyed 77 district attorneys. Over a one-year period, emergency rooms in the sample treated over 300 cases of suspected maltreatment, and district attorneys prosecuted 447 cases. Among the cases treated in hospital emergency rooms, 11 percent of the children died and over 28 percent suffered permanent brain damage. In response, Kempe recommended a uniform system across all states that would let professionals and other concerned individuals report suspected cases to local law enforcement or child protective services. By 1967, all states had adopted some sort of formal reporting standards, many of them mandatory, and had outlined investigative and response procedures.¹⁵

Some cases identified through these state systems mirrored the intentional mistreatment and significant physical injury that Kempe and his colleagues observed. The majority, however, more closely reflected the profiles documented in early population-based incidence studies.¹⁶ This research confirmed that child abuse and neglect reflected poor parenting skills. However, the research also found that even minor parental shortcomings became magnified when families had limited access to quality health care, early supportive services, and adequate income. Maltreatment victims included both children intentionally harmed

by dysfunctional parents and children who might be described as collateral damage from a chaotic and poorly resourced environment that impacted not only their own wellbeing but often their parents' as well.¹⁷

Early Framing

Despite growing evidence that child welfare cases disproportionately included low-income families, those promoting the Child Abuse Treatment and Prevention Act of 1974 explicitly emphasized the universal potential for maltreatment across all segments of society. Facing opposition from the Nixon Administration and resistance from legislators to anything perceived as "another poverty program," advocates portrayed child abuse as an individual problem that could affect any parent.¹⁸ In addition to articulating a uniform child abuse reporting system, the act allocated half of its resources for research to learn more about maltreatment's causes and consequences, as well as promising clinical strategies to address it. This dual emphasis on doing and learning proved politically savvy, and the bill passed with little opposition. But the policy response didn't match the political rhetoric. Because the response system largely centered on investigating identified cases and providing case management, it minimized the variability in parental capacity across the socioeconomic spectrum. The act and the response system it proposed also vastly underestimated what would be required for many parents to avoid subsequent abuse or neglect and to retain custody of their children.

Based on the modest number of reports initially filed (about 60,000 per year), carefully assessing all identified families seemed feasible. And cases where children needed to be permanently removed from

their homes due to serious physical injury or abandonment would be self-evident. But as the number of reports grew, it proved far more difficult to determine which parents should be offered supportive services and for how long. Further, child welfare workers found themselves in the difficult position of judging parental intent with a population often overwhelmed by contextual burdens.¹⁹ Child welfare caseworkers offered their clients a rather narrow range of parenting education, household management, and counseling services. They didn't manage eligibility standards or the availability of income maintenance programs, housing subsidies, or health care services—the very services many parents needed to safely care for their children.

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On one level, the absence of a holistic approach to child maltreatment makes it rather surprising that foster care rates didn't immediately increase. Within a few years, though, foster care rates did in fact rise, as did suspected maltreatment reports. More than two million reports were documented in 1987, representing a 225 percent increase over 1976. By the mid-1990s, the number of children reported as potential victims of abuse or neglect exceeded three million annually.²⁰ During this same period, the number

of foster care placements grew. By 1990, 400,000 children were spending some time in foster care; by 1995, the number had risen to 567,000.²¹

Federal Legislative Reforms

Child welfare's core outcomes—safety, stability, continuity, wellbeing, and permanence—represent a tall mission. Child welfare workers are asked both to keep families together and to keep children safe. If children need to be removed, they must be reunited with their families, or given a permanent alternative, as quickly as possible. In addition to safety and permanency, child welfare workers are expected to monitor and manage children's physical, cognitive, and behavioral health needs. This caseload complexity has led to multiple federal reforms over the past 40 years. Beginning with the Adoption Assistance and Child Welfare Act of 1980 through the recently approved Family First Prevention and Services Act, policy makers have set high expectations, asking the child welfare system to balance the resources necessary to both protect children and preserve families.²² Strategies promoted to support one or more of these policy goals have included:

- Investments in family preservation programs that provided child welfare services to children at risk for placement while they remained in their own homes
- Investments in differential response systems that offer voluntary prevention services to families reported but not substantiated for maltreatment
- Specific timelines for making decisions about permanent placement and accelerating the adoption process

- Incentives for adoption and extended Medicaid eligibility for children placed with relatives who agree to serve as guardians, rather than as adoptive parents
- Extended Title IV-E assistance for foster care, adoption, and guardianship payments to youth up to age 19, 20, or 21

Each reform minimized one issue, often at the cost of complicating another. When more children entered foster care, the policy emphasis shifted to strengthening and expanding services for child welfare cases in which parents retained custody of their children. When the proportion of children reunited with their families within 12 months declined, workers focused on expanding alternative placements through adoption assistance or permanent placement with relatives. Poor educational and mental health outcomes for children served by the system called attention to the need to expand services for behavioral health. Developing a network of interventions within a single agency to address myriad objectives created fluctuating priorities and notable operational challenges.

Funding Reforms

Although only a fraction of children served by the child welfare system are removed from their homes, these cases consume the lion's share of the resources.²³ Of the close to \$8.7 billion federal dollars allocated for child welfare activities in fiscal year 2016, most flowed to states through two sections of the Social Security Act. Under Title IV-E, state agencies received \$7.8 billion (90 percent of the total) to reimburse a portion of the funds they spend on foster care, adoption assistance, and, where applicable,

permanent placement with relatives. In addition, these funds can be used for youth who age out of foster care or are expected to age out without permanent placements. Under Title IV-B, state agencies received an additional \$668 million (8 percent of the total) to support services intended to protect and promote children's welfare primarily through supportive services. Recipients include parents with children in foster care to facilitate reunification, families who have retained custody of their children but remain under the supervision of child welfare workers, and families identified through differential response systems as being at risk of future abuse or neglect.

Between fiscal years 2012 and 2016, the federal investment in Title IV-E—the funding pool that covers the costs of foster care and adoption services—increased by 16 percent. During this same period, the general child welfare—services budget, Title IV-B, declined by 8 percent, while total investments in other child welfare programs remained flat.²⁴ The high cost of foster care, adoption, and other alternative-placement services has historically limited the resources available to expand investments in the clinical and therapeutic services needed to support families and promote positive child development.

In response to demands for greater investments in supportive services for families to prevent foster care placement, the Child Welfare Waiver Demonstrations offered the possibility of shifting resources from foster care payments to direct clinical interventions. Conceived as a strategy to generate new knowledge about innovative and effective child welfare practices, these waivers give states flexibility in using federal funds, particularly Title IV-E money. They

have been available to states on and off since they were initially authorized in 1994. Though the waivers don't increase the total amount of federal dollars a state can receive for child welfare expenditures, states can reallocate any savings that result from their investments in non-foster care services, supports, and innovations.²⁵

Waivers are currently being used by 28 states, the District of Columbia, and one Native American tribe. States can use them to implement established or emerging evidence-based programs to improve participant wellbeing and track the impacts of such services on placement and reunification rates.²⁶ A review of how the waivers affected child welfare agency practice, by the National Research Council Study Committee on Child Maltreatment, found that in many instances the waivers alone didn't give states sufficient incentives to implement and sustain a solid continuum of high-quality, evidence-based clinical interventions.²⁷

Shift toward Prevention

The Family First Prevention and Service Act, approved by Congress as part of the Bipartisan Budget Act of 2018, offers state child welfare administrators yet another opportunity to craft meaningful reforms. As with the Title IV-E waivers, the act encourages states to expand investments in time-limited services designed to reduce the need for foster care, particularly in cases that stem from drug abuse, mental health problems, or a lack of parenting skills.²⁸ In contrast to the existing waivers, this legislation gives states greater financial incentives to adopt the strategy. Under the original waiver program, states received a 50 percent reimbursement for the services they provide only in cases where the child's family

earns less than the amount that would have qualified them for Medicaid reimbursements in 1996. This standard is met, on average, in only 40 percent of cases. By contrast, Family First lets states claim partial reimbursement for the services they offer any child. It also extends the family preservation and support services funded under Title IV-B beyond the current 12-month limit, allowing states to work with families longer before having to determine whether foster care placement is necessary. Last, the act limits federal reimbursements for youth placed in group homes rather than with foster care families to the first two weeks of their placement.

The legislation is not without controversy. Not all advocates believe the policy will improve the lives of children entering the system, and many fear it will compromise the resources and options available to foster care residents.²⁹ Others applaud it and hope most states will develop plans to invest a greater proportion of their Title IV-E funds to expand mental health and substance use prevention and treatment services, as well as in-home skill-based programs such as parent education, home visiting, and individual or family counseling.³⁰ All supported interventions must have some empirical evidence of their efficacy, though they don't have to meet the highest evidentiary standard, that is, repeated randomized trials.

Commenting on Family First's potential to change the child welfare system, Jerry Milner, acting commissioner of the US Administration on Children, Youth and Families, suggested that his agency's primary mission should be to strengthen family resilience: "We need to change the focus of child welfare to primary prevention of maltreatment and unnecessary removal of children from their families. We should

prioritize the importance of families by ensuring that when foster care is necessary, it operates as a support for the family rather than as a substitute for the parent.”³¹

Considering child welfare services as an agent for primary prevention is difficult to square with its operating system and statutory mission. Families enter the child welfare system through a reporting system activated only when someone observes and acts to identify parents who have maltreated a child or who have demonstrated a high likelihood of doing so. Further, Family First prioritizes services for children in foster care or at high risk of placement. This standard presumably favors a child with a history of maltreatment, not those who qualify for primary prevention under any definition of the term.

That said, several well-defined clinical interventions have been proven effective in reducing later maltreatment and improving a child’s physical and behavioral health, even in cases where parent-child relationships are seriously compromised.³² However, it’s less certain that this strategy can reduce placement rates enough to make major investments in clinical services cost neutral. If more resources are directed to children in or at risk of foster care placement, what will happen in cases where families are unable or unwilling to care for their children? Will comparable investments be available for children who have no option but to spend some time, and perhaps even a significant proportion of time, in out-of-home placements? As child welfare systems seek to significantly reduce or even phase out group homes, what new service, staffing, and funds will be required to adequately support foster care parents or others forms of alternative placement?

Several well-defined clinical interventions have been proven effective in reducing later maltreatment and improving a child’s physical and behavioral health, even in cases where parent-child relationships are seriously compromised.

Child welfare administrators have shown little willingness to make the major investment shifts that would be needed to decisively alter the array of therapeutic services available to children both in and out of the foster care system. Their reluctance is understandable. Child welfare will always be pulled between the need to demonstrate system outcomes, such as reducing later maltreatment, lowering placement rates, and reunifying families more quickly, and the need to demonstrate measurable improvements in child wellbeing and parental capacity. And as one seasoned child welfare observer notes, “state [child welfare agencies] would be hard pressed to maintain cost neutrality if they were to undertake innovations to enhance child wellbeing alone.”³³ As child welfare reforms again introduce a prevention mission, they exacerbate the tension between providing sufficient therapeutic interventions to allow children to remain with their parents and optimal interventions for children in care. Improving child welfare’s performance requires new thinking and reframing of its partnership with local networks of prevention services. If child welfare agencies want to

play a role in primary prevention, we also need a new, earlier identification system to reach the most challenged families before patterns and consequences of poor parenting materialize.

The Prevention Response

In addition to advocating for a child abuse reporting system, Kempe promoted primary prevention, calling for, among other things, a universal home-visiting program for all new parents, regardless of family circumstances.³⁴ He described this intervention as “an expected, tax-supported right of every family along with fire protection, police protection, and clean water—societal services that we all deserve to have and from which no one can be excluded.”³⁵ Indeed, a mandated reporting system made sense to Kempe only in a context that included comparable prevention investments. Unfortunately, early interest in prevention didn’t keep pace with interest and investments in the public child protection system. Kempe’s seminal textbook on child abuse, *The Battered Child*, lacked a specific section on prevention until the third edition, published in 1980. Commenting on what the authors’ viewed as a significant addition to their book, Kempe and his coeditor, Ray Helfer, included the prevention section with “great hope and expectation.” “Prevention programs,” they wrote, “are beginning to yield results. The future looks bright.”³⁶

The Prevention Continuum

Efforts to prevent child abuse didn’t start with a unified, national public policy or substantial federal investment. Rather, local advocates led the charge, focusing their attention on raising public awareness around the problem’s scope and impact. National nonprofit organizations, such as the National Committee to Prevent

Child Abuse, the Kempe Center for the Prevention and Treatment of Child Abuse, and the Children’s Division of the American Humane Association, created public awareness campaigns reminding the public that “it shouldn’t hurt to be a child” and urging parents to “take time out; don’t take it out on your kid.”³⁷ Embracing the idea that maltreatment can occur across the socioeconomic spectrum, these messages held parents responsible for making changes—child abuse can be prevented in all families only if parents have the knowledge and support they need.

Perhaps to avoid a direct link with efforts to reduce poverty or social inequities, child abuse prevention advocates rarely focused on policy changes that could affect a family’s economic wellbeing, such as higher wages, better child care, enhanced housing policies, or more generous income maintenance programs.³⁸ Rather, they coalesced around a suite of programs to improve key gaps in parents’ knowledge of child development, the demands of parenting, and home and child management; the quality of the parent-child relationship as observed in the emotional ties and communication between parent and child; parents’ skill in coping with the stresses of infant and child care, as well as the care of children with special needs; and peer support systems to reduce parents’ isolation.³⁹ These programs targeted potential perpetrators and focused on reducing the incidence of physical abuse, neglect, and emotional maltreatment. By contrast, efforts to prevent child sexual abuse focused on reducing the vulnerability of potential victims. These programs, generally universal in reach, offered education and support on inappropriate touching to all children enrolled in schools, early care facilities, and youth recreational and service organizations.⁴⁰

Because child maltreatment lacked a unifying causal theory, dozens of programs sprang up in communities across the country. Each had its own funding streams and practice standards.⁴¹ Advocates solicited funds to support these efforts from foundations, local governments, and individual donors. Beginning in 1980, advocates worked to establish state Children's Trust and Prevention Funds to generate a modest, common funding stream through state legislative authorizations, surcharges on birth or marriage certificates, personal income tax line-item contributions, and private fundraising. The legislation that established mandatory reporting in each state (the Child Abuse Prevention and Treatment Act of 1974, or CAPTA) is the sole consistent federal support for prevention services. In contrast to the nearly \$8.7 billion federal dollars allocated for child welfare activities in fiscal year 2016, however, CAPTA, which has maintained a modest level of funding over the past 40 years, in the same fiscal year allocated about \$40 million to support community-based prevention services.⁴²

Every community had a publicly funded child protection system, but no community had a coordinated, easily identified prevention system. The content, characteristics, and structure of parent support services reflected each community's interests and unique funding opportunities. Program selection often had more to do with style than substance. Program evaluations, when they were done at all, lacked strong designs or measures, paying minimal attention to such issues as selection bias, preexisting conditions, and external factors that might account for suggested program effects.⁴³ Families often accessed an intervention not because it was the best fit for their needs but because it was the sole option available.

And with wide variation both across and within states regarding who offered these services and their eligibility criteria, it was hard for parents to know where to look for assistance or what help they might receive. The prevention continuum did a good job in creating a service market, but it didn't create a preventive system that could attract and retain families unable to manage this market or who faced the greatest challenges.⁴⁴ Reaching families at high risk required not just more services but services that understood how various chronic and acute circumstances might influence, in different ways, parents' perceptions of their children, their capacity to care for those children, and their willingness to change.

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Shift to Early Intervention and Evidence-Based Practice

Two trends in the 1990s gave rise to a more consistent prevention response: neurological research documenting how early experiences affect a child's life trajectory and a policy shift toward directing social service investments to programs proven to be effective through rigorous research. In the first instance, advances in neuroscience provided vivid imagery of how early trauma and a lack of adequate emotional care affects an infant's developing brain.⁴⁵ Translated for popular consumption by the Carnegie Foundation's

Starting Points report and lengthy feature articles in *Time* and *Newsweek*, these images proved as powerful as Kempe's initial work in generating public interest in the issue.⁴⁶ In response, the child abuse prevention field, as well as the broader early childhood community, shifted toward strategies to strengthen early parent-child attachment and promote healthy child development.⁴⁷

The growing evidence that high-quality early intervention programs could make a difference in a child's developmental trajectory proved equally important in changing the prevention landscape. Studies of early childhood programs implemented in the 1960s and 1970s that followed participants into adulthood found marked improvements in long-term educational outcomes and adult earnings compared to children not enrolled in these programs.⁴⁸ Most relevant for child maltreatment, David Olds and his colleagues published the results from a randomized clinical trial of a nurse home visiting program first implemented in Elmira, NY. His research documented program impacts on a range of child and parent outcomes, including a reduction in substantiated child maltreatment.⁴⁹ Follow-up studies on the original population, as well as additional randomized trials of the model in Memphis and Denver, further supported the program's efficacy.⁵⁰ At the same time, practice and political interest in early home visiting grew as other national and state home visiting models extended their reach. The Government Accounting Office (GAO) issued a report in 1990 summarizing research on an array of home visiting and early child development programs. The GAO concluded that home visiting, when well implemented, improved both the short- and long-term health and wellbeing of families and children.⁵¹

Drawing on this report, as well as the history of early home visiting in many European countries and the state of Hawaii's success in implementing universal screenings of all newborns, the US Advisory Board on Child Abuse and Neglect called for a universal system of home visitation for newborns and their parents. "Complex problems do not have simple solutions," the Board wrote. "While not a panacea, the board believes that no other single intervention has the promise that home visitation has."⁵² Though the board's report didn't have a measurable impact on federal policy at the time, it galvanized advocates working on child-maltreatment prevention, family support, and early childhood around a shared mission. Rather than calling for investments in a broad range of strategies, prevention advocates began to emphasize investing in supports for pregnant women and new parents.⁵³ Early home visiting became the best—and in some communities the only—bet for preventing child maltreatment, improving parental capacity, and fostering optimal child development. A network of early home-visiting programs emerged across the country, creating a consistency in child-abuse prevention that would have been unthinkable a decade earlier.⁵⁴

Over time, the focus on a single prevention strategy raised some concerns. As an example, compare the conclusions from two *Future of Children* issues on the topic. The first, published in 1993, lauded the strategy, recommending that the "use of home visiting be further expanded. This could be done through demonstration projects in particular communities or through large-scale, national initiatives."⁵⁵ Six years later, initial optimism had waned. Given the intervention's rapid spread and a corresponding increase in evaluative data, the editors had anticipated

that revisiting the topic would justify their early enthusiasm. Unfortunately, the editors said, the new research was “sobering.” Writing in 1999, they recommended that “any new expansion of home visiting programs be reassessed in light of the findings presented in this journal issue. We further urge that existing programs focus on program improvement, that practitioners and policy makers recognize the inherent limitations in home visiting programs and embrace more modest expectations for their success, and that home visiting services [be] funded as part of a broad set of services for families and young children.”⁵⁶

In response, the developers of national home visiting models sharpened their performance expectations, sharpened the number and structure of direct service practices that replication sites had to adopt, and strengthened their monitoring, supervisory standards, and accountability systems. Despite concerns over the lack of uniform efficacy within and across all models, prevention advocates continued to value the goal of reaching pregnant women and new parents and giving them the necessary knowledge and skills to enhance their parental capacity. Home visiting programs became more widely available, often integrated with a community’s system of early childhood care. And the face of prevention and parent support became more consistent across communities and more visible to child welfare administrators.

Shift toward Treatment

The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), authorized as part of the Affordable Care Act of 2010, solidified home visiting’s central role in preventing child abuse and promoting

child wellbeing. Though it wasn’t the first attempt to direct significant federal resources to early home visiting, MIECHV’s initial \$1.5 billion investment, and its reauthorization in 2018, established a sizable and stable funding stream for early home visiting and identified an entity to manage the program in each state.⁵⁷ Like the Sheppard-Towner Act, MIECHV extended services into underserved areas, such as rural counties, tribal communities, and US territories. More communities now offer early home visiting as part of their prevention continuum, and nearly 70 percent of the states are replicating multiple models, offering new parents more opportunities to access early support.⁵⁸

MIECHV’s emphasis on replicating proven, evidence-based programs and setting common performance standards has ushered in a new level of rigor and expectations for prevention. MIECHV grantees are required to report common aggregate information on the number of parents and children served, the demographic characteristics of program participants, and various service characteristics (for example, the specific evidence-based program being implemented, or the proportion of families who successfully complete the program). It has also extended the mission of early home visiting far beyond the notion of preventing child maltreatment. Home visiting is increasingly viewed as the universal elixir for a range of child and maternal health and behavioral problems. States, through home visiting, are expected to improve maternal and newborn health; reduce child injuries, abuse, and neglect; improve school readiness and achievement; reduce crime or domestic violence; improve family economic self-sufficiency; and improve coordination and referral for other community resources and supports. These goals have been embraced by other initiatives

calling for a consistent set of outcome indicators around home visiting, such as those developed by the Pew Home Visiting Data for Performance Initiative, which states are advocating to document the collective impacts of all their early intervention efforts.⁵⁹

Home visiting programs feel significant pressure to use more aggressive outreach strategies and limit enrollment to parents who are struggling.

MIECHV has improved service availability and measurement, but sadly, it's also contributing to the notion that prevention services, like child welfare services, are best limited to parents at high risk for failing their children. MIECHV-funded home visiting programs feel significant pressure to use more aggressive outreach strategies and limit enrollment to parents who are struggling with problems like opioid addiction, homelessness, poor maternal mental health, or family violence. This is not a new focus for prevention investments. Certain early home visiting programs were designed for and have proven effective with this population. Some programs reach this population by screening a broad range of potential recipients and prioritize those with prior trauma or psychological challenges. Others capture this population by establishing eligibility criteria that limit access to parents with certain demographic or descriptive characteristics suggesting higher need (first-time mothers, teen parents, low-income families).⁶⁰ All of the models engage a proportion of high-risk

parents and, in certain cases, find that their impacts are strongest with these families.⁶¹ But families that face significant challenges represent only part of prevention's target population. Families commonly access home-visiting programs through other health and social-service providers with whom they have an existing relationship. There is no question that many new parents who enroll in these services struggle because of abuse, neglect, or other adverse childhood experiences, instability in their current living conditions, limited education, or lack of social support. However, many also have various strengths, such as supportive extended families, a capacity to navigate complex service systems, and a desire to identify and access available resources. Indeed, these and similar strengths often contribute to their successful enrollment and retention in voluntary services.⁶²

The question is not whether primary prevention programs should be offered to families at highest risk. Rather, the challenge is to discern whether focusing on the highest-risk families will maximize the strategy's population-level effects and how this shift will impact operations and public perception of who might want these programs. Assuming that staff can be armed with the tools they need to address the complex personal and parenting challenges that high-risk families face, other questions remain: How many families can a home visitor successfully engage, particularly when a program is asked to enroll more troubled families? What are the implications of a higher-risk target population for home visitor qualifications, training, and supervision? What does this mean for the cost per participant to deliver these programs? What goals should home visitors directly address, and when do they need to refer families to

others for meaningful assistance? How can home visiting programs that were designed to enhance parental capacity tackle other behavioral or contextual issues without compromising their original mission?

Some very high-risk families can and will successfully engage and thrive in voluntary programs, assuming both the program and its community referral network are sufficient to meet their needs. Other parents won't be able to fully participate in a voluntary parenting program that they may not see as particularly valuable or worth their time given their daily struggles. Improving the reach and efficacy of early home visiting and comparable prevention programs requires more nuanced planning with other systems that serve the highest-risk families, particularly local child welfare agencies. We need new thinking about how to assess parents and direct them to a level of service best suited to their needs and their capacity to stay enrolled.

Building an Integrated System

Brookings Institution scholar Gilbert Steiner began his 1976 book on how to structure family policy with a quote from Grace Abbot, the first director of the Children's Bureau. Writing in 1938, Abbot noted that "all children are dependent but only a relatively small number are dependent on the state."⁶³ Reflecting on this quote, Steiner characterized the "lucky child" who avoids dependency on the state as one whose "biological parents provided a home for them; who spent their preschool years and after school hours in or around their homes; had adequately and reasonably nutritious meals at home; and were examined and treated periodically by private physicians and dentists."⁶⁴ If we applied these standards to

today's children, we could label many children in the United States as "unlucky." And the proportion of unlucky children would grow exponentially if we added such qualifiers as stable homes, safe neighborhoods, or consistent and affordable health care. In truth, all families need outside help; the question is how best to direct them to such assistance in ways that value parental autonomy but also embrace a public commitment to child safety and wellbeing.

Broad policy initiatives, such as raising the minimum wage, extending child-care credits, offering paid family leave, enacting comprehensive health care reform, and providing stable housing, are frequently mentioned as strategies to reduce the parental stress associated with poverty and to create a context more hospitable to parents who are seeking to do right by their children.⁶⁵ But even if we initiated all these reforms, child rearing would still be challenging. Many parents manage the challenges through personal networks or community resources. The initial CAPTA debate failed not because policy makers were reluctant to link child maltreatment to poverty but because they failed to design a system that recognized and tried to alleviate the inequities in parental capacity that inevitably surface when parents have unequal access to supportive services and contexts.

As the nation's child welfare system seeks to minimize the need for costly and often harmful out-of-home placements, and as early home-visiting programs ponder how to identify, recruit, and retain the most challenged new parents, we have the opportunity to create a new paradigm that explicitly recognizes parents' universal need for support. But to do so, we must weave together today's fragmented public and

private, voluntary and mandatory resources into a comprehensive system of care—a tall order. It would require making all parents comfortable with asking for and using help, particularly when informal support is limited. Seeking out and accepting formal public services to help meet parenting demands should be as acceptable as using preventive health care. We also must recognize that the appropriate level of assistance will vary depending on parents' needs and skills. For some parents, voluntary prevention programs may not be enough, just as certain medical and health conditions require more intensive therapy. Asking for help may lead to the need for mandated services or child welfare involvement. The gold standard in this new system should not be to avoid the child welfare system entirely. Rather, we need to ensure that our parent support and child protection systems are fair and efficient, allocating the most costly, intensive, and (in some instances) intrusive options only to families who have exhausted other opportunities.

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What would this new system involve?

First, we need to change the way we view the nation's parent support and child protection

mission. That means a shift from seeing offers of assistance as intrusions into family life to viewing them as opportunities to level the playing field. Early public initiatives, such as the Sheppard-Towner Act, centered on the belief that improving outcomes for all children meant addressing common needs and creating a context to help parents do the right thing. In essence, a public health approach to problem-solving is the science of protecting and improving the health of people and their communities. It focuses on preventing problems not simply by altering individual behaviors but by creating an environment in which desired behaviors are easier to adopt and maintain.⁶⁶ This approach to problem-solving works if we accept the notion that collective goals are best realized when individuals act in ways that support their own health and the health of others.⁶⁷ Preventing child maltreatment and strengthening parental capacity requires more than a single public agency and service strategy, or even a series of targeted prevention services. It requires a system of care that recognizes that all parents face common challenges and that these challenges require both a collective and individual response. A universal commitment to help all parents care for their children establishes the foundation necessary to efficiently allocate scarce public resources and create a social context that is more respectful of parental autonomy and more responsive to child safety and wellbeing. Waiting for parents to fail before justifying offers of collective support becomes unacceptable.

Creating this shared understanding will require new strategies that encourage rather than mandate individual involvement. In framing this problem around the adoption of a universal year of service, Isabel Sawhill of the Brookings Institution suggests that

although we can certainly mandate such a policy, a more prudent path would be to create “a strong expectation that every US resident give one year of service and be provided a structured opportunity to do so.”⁶⁸ In other words, raise the expectation and set the standard while creating a system that is inviting, accessible, and capable of completing the task at hand. The current child welfare reporting system is fundamentally flawed in this regard. It acts as a gatekeeper to a system designed to determine whether parents have the capacity to keep their children. We need a universal and consistent method to discern both what families need and their capacity and willingness to use the available help. In most cases, their needs will be met through voluntary services or informal support networks. But in some percentage of cases, the best fit for families may be the services offered and managed by local child welfare agencies. As other authors report in this issue, we know from models that have already been developed and tested that universal offers of support to all new parents can be crafted in ways that produce high levels of acceptance and measurable change at both the participant and population level. That is, we can offer preventive services without creating a sense of intrusion.

What we haven't tested yet is how well such a system will operate if one possible outcome is a family being directed to the child welfare system, where services may be mandatory or, at a minimum, there are clear consequences for families who refuse assistance. At present, we have limited data about how best to make these determinations and how to introduce this concept to a community already leery of its public child welfare system. However, a referral to child welfare need not be viewed as a failure on the part of the family or even

the system. Rather, child welfare needs to be viewed as an alternative intervention system in which placement may be required to realize the important goals of child safety and healthy child development. We have a reporting system and mandated child welfare interventions because we need them. This need can never be totally eliminated. To suggest that foster care represents failure or that children entering this system have had their life trajectory forever damaged is to fuel anger at the system and intensify public distrust. Removing children from their parents is not ideal. But we can minimize the need to do so by having universal conversations with all parents and by offering help at key points in a child's development, beginning at birth. And if preventive services aren't enough and temporary placement or alternative care becomes necessary at any point, these options can be enhanced and harm minimized through high-quality therapeutic and educational services for both parents and their children.

State child welfare agencies that adopt the Family First framework have an opportunity to work in partnership with those implementing evidence-based prevention services, as well as state public health and welfare agencies, to create a broad network of services. Such a partnership can reduce the longstanding gap between mandated and voluntary parental assistance and can build an integrated, more effective child-protection system. For this partnership to be truly innovative, it will be equally important to move toward a community-owned, universal-assessment strategy, initially reaching all new parents. This universal platform would neither replace a community's mandated reporting system nor be managed by the child welfare

agency, and it would not be a case-finding tool. Rather, it 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. In implementing this system, local service providers can build a consensus around shared parenting expectations and can identify ways that current eligibility criteria, referral links, and capacity limit public agencies' responses.

Through strong, sustained partnerships across agencies that support all aspects of family life, including not only traditional child welfare and family-support services but also preventive health care and an array of primary supports that all or most parents use (such as child care, adequate housing, sufficient income, support from family members and friends), we could shape the

public understanding around collective parenting and improve both participant- and population-level outcomes. The data generated through a common assessment of the resources all parents have available and the extent to which these resources adequately address their needs would give communities rich, real-time information on what parents say they need the most, as well as on the community's collective capacity to meet those needs. Such data would offer both child welfare and preventive services an empirical basis to assess their investment strategies and to redirect their efforts to reinforce one another's missions. Under this scenario, child protection would become a broadly shouldered responsibility in which child welfare is but one player in a network of institutions committed to shoring up parents and ensuring the safety and wellbeing of all children.

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