Using the Family First Act to Grow and Nurture Support Systems for Families of Young Children

A look at promotion, prevention, and Family First Act implementation in six states

Rebecca Vivrette, Amy McKlindon, Elizabeth Jordan, Maggie Haas, Ja'Chelle Ball, Gina Mueterthies, Jaclyn Szrom, and Torey Silloway

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Executive Summary

Early childhood is a developmental stage ripe with opportunities to support the healthy development of children, promote family well-being, and prevent the adverse effects of child maltreatment. States and communities across the country are taking different approaches to building out a robust continuum of prevention services and supports for families. Child- and family-serving systems, including child welfare and early childhood, play distinct but overlapping roles in providing support to families depending on their individual circumstances.

Through interviews with a range of child- and family-serving agencies and organizations across six states (Colorado, Michigan, Nebraska, New York, South Carolina, and Washington), we examined the current state of prevention and promotion efforts for families with infants and toddlers and how states are leveraging newer opportunities such as the federal Family First Prevention Services Act (Family First Act).[1] We also explored facilitators and challenges states are facing as they seek to promote the holistic well-being of infants, toddlers, and their families and to prevent maltreatment and entry into foster care.

Prevention is a priority issue for child welfare agencies and their partners.

Across the board, each state expressed deep commitment and coordinated action designed to increase access to prevention services for families, including those with young children. Cross-system partners are enthusiastic about the ways in which they have begun expanding prevention services and have demonstrated great creativity in leveraging available, although limited, resources. Services for families with infants and toddlers include home visiting, infant and early childhood mental health services and supports, pre-and postnatal services, parental substance use treatment, Infant-Toddler Court (ITC) teams, and child care.

States are leveraging the Family First Act as an opportunity to maximize their resources for prevention across existing funding streams and build out a more robust continuum of primary, secondary, and tertiary prevention services, with a focus on moving supports as far "upstream" as possible. Child welfare agencies have historically operated at the secondary and tertiary prevention levels, supporting families with one or more risk factors for maltreatment (secondary prevention) and seeking to mitigate the harmful effects for families when maltreatment has already occurred (tertiary prevention). While the Family First Act reinforces this focus by requiring that children be at imminent risk for removal from their families in order to qualify for services, it has also spurred new activity. Planning for implementation has also brought new partners together across previously siloed systems and invigorated existing collaboration efforts.

While there are similarities across the states in their commitment to supporting families and preventing maltreatment, each state is also situated uniquely in its current and historical context. The six states therefore started their Family First Act planning from different places, which has shaped the opportunities they have stepped into. For example, some states had a strong infrastructure in place to deliver evidence-based practices (EBPs) through current providers, whereas others are building out a new service array and educating their caseworkers on these newly available services. Some states had strong cross-system relationships in place that facilitated more immediate collaborative planning, and others have used the Family First Act as an opportunity to build out needed partnerships. States are building on what they already had in place as they grow their prevention and promotion systems.

[1] The Family First Act allows states to draw down federal Title IV-E funding for services to prevent children from entering foster care. For more information on the Act, please see the full report.

Prevention efforts are grounded in collaborative approaches, a focus on equity, and family engagement.

Holistic and responsive prevention systems extend far beyond the child welfare agency. States described cross-system collaboration as essential to supporting families. No one agency or organization can do this work alone, and it takes combining collective expertise and resources across partners to ensure families can access the supports they need within their communities, without entering the child welfare system. Each of the six states described using multisystem collaborative groups and regular cross-agency meetings to build and sustain the relationships needed to work in partnership. While partnership is essential, it is not easy; states described the importance of leaders committing to collaboration in the face of competing demands and priorities, and of all partners taking the time to develop relationships.

Prevention efforts must acknowledge and actively address the role of systemic racism and historic/current inequities in creating overrepresentation of Black, Hispanic, and Indigenous families; families living in poverty; and families with unmet health and behavioral health needs in the child welfare system. Strategies to advance equity used by states include conducting needs/readiness assessments, building equity into strategic plans and state budgets, establishing working groups, creating tools and resources, and focusing on building trust with families and communities who have been marginalized. Recognizing the unique government-to-government relationships between states and Tribes, tailored strategies to build and maintain relationships are needed to advance more equitable outcomes for Indigenous children and families. Each state also identified challenges to advancing equity through their prevention work (e.g., geographic access to services, a lack of culturally responsive services) and acknowledged that there was more work to be done (e.g., strengthening state-Tribal partnerships).

Each of the six states is striving to include individuals with lived expertise in their prevention planning, with room for ongoing improvement. One approach states have used to advance equity is engaging lived expertise throughout the development and implementation of prevention efforts. Some family engagement opportunities were more transactional (e.g., data collection), while others allowed for shared decision-making. The states most commonly engaged families in their planning through structured committees or advisory councils, either made entirely of individuals with lived expertise, or by bringing individuals with lived expertise together with other system partners.

As their prevention efforts evolve, states are navigating funding complexities, misalignment between the available service array and families' needs, and workforce capacity challenges.

While states braid together a variety of federal, state, and philanthropic funding sources to fund their prevention efforts, the funding requirements are complex and the available resources are insufficient. The requirements of the different sources can pose administrative challenges for both service providers and state agencies administering the funds. Restrictions and requirements for each funding source vary, as do the monitoring and billing systems used across agencies and divisions. Complying with the varied requirements is complex and time consuming, sometimes taking more effort than states can invest. Some states have not yet been able to draw down federal Title IV-E funding through the Family First Act due to administrative and data hurdles. States described the necessity of braiding together multiple funding sources for sustainability but stressed that available funding is not flexible enough to support the prevention work they envision.

The existing service array does not always align with families' needs. Broadly, service availability can be limited in rural and frontier areas, and implementing evidence-based interventions can be prohibitively expensive. Specific to the Family First Act, states highlighted the importance of providing for families'

concrete needs, which is not reimbursable under the law, as well as the dearth of eligible programs designed for families of color, and for Black, Indigenous, or Hispanic families in particular.

Relatedly, the need to build and enhance the capacity of the child- and family-serving workforce remains a challenge to implementing prevention services. Specific workforce gaps include clinicians and other professionals trained to work with infants and toddlers; bilingual staff; staff who meet the credential requirements for various EBPs, particularly in rural areas; and mental health and substance use practitioners, including those specializing in infant mental health. States also described the importance of nurturing agency culture changes among child welfare case managers to shift to a prevention mindset and develop their understanding of available evidence-based programs in their communities. As states seek to incorporate greater family voice into their planning for practice and systems changes, many are also prioritizing hiring individuals with lived expertise to provide direct support to families.

Conclusion

States are optimistic about new and growing prevention efforts and eager to provide additional supports for families—including families with infants and toddlers—that truly meet their needs and reduce child maltreatment and child welfare system involvement. With the current emphasis on expansion, this is an ideal time for new and constructive partnerships between child welfare and early childhood agencies to set common goals, leverage new opportunities, and navigate challenges.

As states across the country continue to invest in prevention, we conclude the report with recommendations designed to help state leaders:

- Reduce silos across and between agencies and their partners.
- Increase supports specifically designed to meet the needs of families with very young children.
- Promote equity in policies and practice, and bring parents with lived expertise into decision-making roles.
- Facilitate the use of the federal Family First Act in their overall prevention efforts.

Introduction

The greatest opportunity to influence a child's success is from the very start. Every baby has enormous potential, and every family wants to help their child reach this potential. All families need support from their community of family, friends, caregivers, and educators. Public systems play an important role in supporting communities and families in creating the safe, stable, nurturing environment children need. Yet, families with young children often face challenges stemming from economic insecurity, material hardship, and stressful experiences that can undermine healthy development. Due to the intergenerational effects of and lived experiences with institutional and interpersonal racism, Black, Hispanic, and Indigenous families disproportionately face these challenges, leading to inequities in opportunities for their young children.

Building an integrated child and family well-being system includes strength-based approaches to providing health and family well-being promotion and prevention services. These systems promote early developmental health and family well-being with a prevention lens to mediate risks and negative outcomes, including preventing entry into the child welfare system.

In both child welfare and early childhood fields, policymakers and practitioners are investing in providing more robust and coordinated services for families. Systems across the country are recognizing the need to couple traditional prevention services—such as mental health, substance use, and in-home parent services –

with concrete supports that meet basic needs like food security, housing assistance, and transportation. To better understand how states are coordinating systems of formal (e.g., programs, services) and informal (e.g., family, peer-to-peer, community) supports to buffer the effects of conditions such as racism and poverty on families with infants and toddlers before a crisis occurs, we interviewed state leaders from multiple systems in six states.

This study focuses on how states are using funding through the federal Family First Prevention Services Act (Family First Act)—including programs in the Title IV-E Prevention Services Evidence-Based Clearinghouse (Clearinghouse)—as one piece of their efforts to strengthening states' infrastructure to reach all families, and how they have identified the funding streams and partners needed to provide a continuum of state and community-based prevention services to families with infants and toddlers. We hope states reading this brief can learn from the challenges other states are facing in creating a system of promotion—promoting the well-being of young children and families across primary, secondary, and tertiary prevention—that successfully support families in ensuring very young children can thrive while remaining safely in their home.

In this report, we begin by describing our process for determining which states were invited to join the study and how they were engaged. We then provide background data on each of the participating states. Next, we discuss four key findings that arose from this study:

1. Prevention efforts—from development, to funding, to implementation—vary widely across states and communities.
2. States utilize an innovative range of services that are designed to meet the unique needs of families with young children; however, they are not available in every state or community.
3. Each state is trying strategies and facing challenges to promoting equity and incorporating parent voice in their prevention planning and implementation.
4. Although states have faced implementation challenges with the Family First Act, it is playing a unique and important role in overall prevention efforts.

The report concludes with overarching reflections and recommendations for state and federal policymakers to continue to grow and nurture a prevention system that truly meets the unique needs of families with very young children.

Of note regarding terminology and interpretation of findings throughout this report, we use the term "state" to attribute themes and findings; we do not quantify the number of individuals within a state that identified each theme or finding and acknowledge that not every individual participant or agency in each state may share one another's perspective. Although we used a semi-structured interview guide, we also allowed for flexibility during interviews, depending on the perspective and role of the participants. As a result, all topics included in the semi-structured interview guide may not have been covered in every interview.

Study Overview

Methodology

For this study, we interviewed six states (Colorado, Michigan, Nebraska, New York, South Carolina, and Washington) that have established prevention systems, are implementing or close to implementing Title IV-E Prevention Program Five Year Plans (Prevention Plans) through the federal Family First Act, and represent a variety of geographic locations and political affiliations. To identify states to invite to

participate, Child Trends and ZERO TO THREE reviewed state-level information for all 50 states on a number of metrics, including:

- Individual state Prevention Plans, submitted and/or approved, with a close review of any stated focus on infants and toddlers, early childhood system collaboration, and engagement with parents, youth, and/or Tribes;
- Participation in prevention initiatives, such as Thriving Families, Safer Children and/or Community Collaborations to Strengthen and Preserve Families and/or availability of early childhood initiatives, such as Infant-Toddler Court (ITC) sites and/or early childhood advisory councils;
- Available services for parents and infants in state Plans of Safe Care;
- Child welfare agency administration (county or state administered);
- Geographic location; and
- Political composition of the legislature and governor's office.

We also consulted with several experts in the prevention, health, mental health, and substance use fields to understand key issues and gather intel on states doing innovative or effective work. After reviewing this information, we identified six states for participation that had a strong prevention system in place and brought a diverse set of goals, priority areas, geographic locations, and political affiliations. The number of states selected was designed to capture depth and breadth of prevention approaches within the timeline and resources provided for the project.

Child welfare administrators were contacted and invited to participate in an introductory interview. These administrators then provided insights and recommendations to the research team, helping us identify and connect with between five to nine other entities in the states involved in prevention efforts and/or early care and education efforts. Five of the six initially selected states agreed to participate. One state was unable to participate, so another state with similar geographic, political, and prevention systems was selected to participate in the study.

In total, 47 professionals participated in one-hour virtual interviews. These professionals represented a range of agencies and organizations, including child welfare, early childhood, child care and early education, early intervention, health and mental health, substance use, community-based and advocacy organizations, and court systems. A semi-structured interview guide included questions on agency definition and vision for prevention, infant/toddler prevention efforts, collaboration, and partnerships—including those with community-based programs and Tribal entities, funding, and barriers and facilitators to prevention. We hoped to connect directly with Tribal entities in each of the geographic regions of the six states, as well as parents/caregivers with lived expertise in child welfare involvement; however, due to a number of factors, we were unable to incorporate those interviews into the research design. We did probe state representatives specifically on their engagement with Tribal entities, their delivery of culturally responsive services and supports to Tribal communities, and their efforts to engage parents/caregivers in decision-making and program implementation. We also identified parents/caregivers with lived expertise in child welfare who were already working with ZERO TO THREE on parent/caregiver leadership initiatives, including parent leaders serving as paid members of the Infant-Toddler Court Program National Resource Center team and members of the National Advisory Group for Parents' Voices. While not representative of all parent/caregiver experiences with child welfare, and with a wider parent/caregiver-focused data collection strategy being out of scope for the current project, our goal was to solicit feedback and perceptions from a handful of parents/caregivers to better inform and interpret the findings. In a focus group with three parent leaders/advisory group members, we asked about the availability of prevention services, family needs and preferences for service delivery. We also requested their feedback on early findings from the study.

Background information on participating states

We are incredibly grateful for the time and thoughtful engagement with our six study states: Colorado, Michigan, Nebraska, New York, South Carolina, and Washington. Table 1 summarizes contextual information about each state, including the proportion of children experiencing maltreatment who are infants and toddlers, percent of local/state and federal funds spent on prevention services, and the availability of prevention initiatives and ITC teams.

Table 1. Study participant states contextual details

State	% children who experienced maltreatment, ages 0-3 (FFY 2021)[i]	% children entering foster care, < age 3 (FFY 2021)[ii]	% state/local funds spent by child welfare agency on prevention (SFY 2020)[2, iii]	% federal funds spent by child welfare agency on prevention (SFY 2020)[2, iv]	County or state administered[v]	ITC/Thriving Families, Safer Children[vi,vii]	Family First Prevention Plan and date[viii]
Colorado (CO)	32%	31%	26%	9%	County	Both	Colorado Plan (Approved 9/2022[ix])
Michigan (MI)	33%	37%	3%	5%	State	ITC	Michigan Plan (Approved 7/2022[x])
Nebraska (NE)	33%	27%	6%	1%	State	Both	Nebraska Plan 2020 (3rd Ed.) (Approved 2/2020[xi])
New York (NY)	25%	32%	19%	2%	County	Both	New York State Plan (Approved 8/2022[xii])
South Carolina (SC)	33%	25%	2%	22%	State	Both	South Carolina Plan (Approved 1/2022[xiii])
Washington (WA)	32%	42%	Unknown[3]	Unknown[4]	State	ITC	Washington Plan (Approved 10/2020[xiv])
US Total	34%		16%	11%			

[2] The percentage of child welfare agency expenditures of state/local and federal funds on prevention include state-reported child welfare agency spending on parent-skills based programs, substance use prevention/treatment, mental health treatment, financial supports, caseworker visits/administration, and other.
[3] Washington was unable to participate in the Child Welfare Financing Survey in SFY 2020.
[4] Washington was unable to participate in the Child Welfare Financing Survey in SFY 2020.

Key Findings

Our interviews covered topics related to overarching prevention strategies, motivations, and reasons for shifts in the prevention services array; prevention financing strategies; Family First Act implementation; the role of equity in prevention planning; and collaboration strategies for other prevention entities in the state, parents, and Tribes. Four key findings emerged.

Key finding 1: Prevention efforts—from development, to funding, to implementation—vary widely across states and communities.

States value prevention and have set goals around ensuring a robust service array is available for families.

Interviewees across all states - representing a wide variety of different public agencies - recognized the importance of prevention and were committed to enhancing access to full-spectrum prevention services, including primary, secondary, and tertiary prevention approaches (defined in textbox). Despite the universal awareness and commitment to preventing child maltreatment and child welfare involvement, each state was unique in its approach and capacity to deliver prevention services. States were at varying timepoints in their "prevention journeys" – both in terms of how long they had engaged in prevention work and how far upstream their prevention services reached. Each state leveraged different strengths and had a range of priorities based on the needs of the families within their state. Child welfare agencies across states largely described themselves in the secondary and tertiary prevention space for children already identified as at risk, with partners outside of child welfare conducting "upstream" primary prevention (e.g., home visiting).

Types of Maltreatment Prevention Services

Primary prevention activities are directed at the general population and attempt to stop maltreatment before it occurs. All members of the community have access to and may benefit from these services.

Secondary prevention activities with a high-risk focus are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance [use], young parental age, parental mental health concerns, and parental or child disabilities.

Tertiary prevention activities focus on families where maltreatment has already occurred (indicated) and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence.

Framework for Prevention of Child Maltreatment (Child Welfare Information Gateway)

As such, states have invested in prevention primarily by:

- Expanding current prevention services and programs (e.g., expanding home visiting age eligibility in NY, providing additional funding to agencies to deliver culturally responsive practices to families at risk for or involved in the child welfare system in WA)
- Restructuring agencies and agency visions to promote partnership and collaboration (CO, MI, NE)
- Prioritizing services and addressing family needs more holistically (e.g., family resource centers, central database portals [CO, NE, NY, SC], economic stability support pilots [NY]).

States discussed what factors have helped facilitate the growth and expansion of prevention. All states reported that establishing cross-system committees or working groups whose mission—at least in part—is to enhance prevention supports for children and families helped to accelerate prevention efforts. Most states highlighted that commitment from state leadership to invest in and value prevention as a top priority for children and families is a key ingredient to advancing prevention services (WA, CO, MI, NE). Newly available funds– such as the federal Family First Act (discussed in Key Finding 4) – also opened the door for growth and change in each of the states.

Collaboration is a central strategy in every state and a wide array of partners are engaged.

All states emphasized that strong cross-system partnerships are necessary to delivering high quality prevention services and shared a number of examples of partnering systems and agencies to deliver services to families. There are unique benefits and challenges for close collaboration between early childhood and child welfare systems. See **Key Finding 2** for more information on state strategies to connect these two systems specifically. The list below outlines general system areas and the partners noted by states during interviews.

State perspective: Washington

"I'm not just trying to work with existing networks. I am also trying to seek out where can we help support and build capacity for better collaboration by and for organizations who are already embedded in community and are already doing healing centered work with families, and how we support and grow their ability and capacity to support families."

System areas and partners identified by states[5]

Child welfare/Department of Social Services/Child Protective Services

- Child advocacy centers
- Child maltreatment boards
- State/county Department of Child Welfare
- State/local Department of Social Services

Early childhood agencies and programs

- Attachment and Biobehavioral Catchup
- Child Care Resource and Referral Network
- Circle of Security
- Early Head Start
- Help Me Grow
- Home visiting programs
- IDEA Part B/C Office
- Office of First Steps
- Start Early Washington
- State Department of Early Childhood
- State Early Childhood Advisory Council
- State Office of Superintendent
- Strengthening Families
- Universal Pre-K program

[5] There is some natural overlap between system areas, and states sometimes include partners in different categories. There are also different potential partners available in each state, and states often use different names to describe similar partners. Partners are listed in alphabetical order.

Health/mental health/behavioral health/public health

- Child/Parent Psychotherapy Center(s)
- HealthySteps
- Local/state hospitals
- Office of People with Developmental Disabilities
- Office of Rural Health South Carolina
- State Behavioral Health Administration
- State Department of Healthcare Policy
- State Essentials for Childhood
- State Infant Mental Health Association
- State Maternal Child Health Program and Breastfeeding Coalition
- State Medicaid
- State Office of Health/Public Health/Economics

Substance use

- National Center on Substance Abuse and Child Welfare
- Residential/Inpatient Maternal Substance Use Treatment Centers
- State Department of Alcohol and Other Drug Abuse Services

Concrete and economic supports

- State Grocers Association
- State Office of Public Health/Economics
- TANF

Courts/law enforcement

- Children's Law Center of South Carolina
- Local/state courts and judges
- Nebraska Court Improvement Project
- Police departments
- Infant-Toddler Court (ITC) teams
- State Department of Juvenile Justice
- State District Attorney

Tribal Nations and government

- Individual Tribes and Tribal leaders
- Society of Care and Counseling/Morningstar Counseling
- State Office of Tribal Relations
- Urban Indian Center

Non-profit/foundation

- 10 Point Boule Foundation Colorado
- Annie E. Casey Foundation
- Bring Up Nebraska
- Caring for Kids Colorado
- Children's Trust of South Carolina
- Community stakeholder/advocacy groups
- Families Together New York
- Illuminate Colorado
- Invest in Kids Colorado
- Prevent Child Abuse America
- Prevent Child Abuse New York
- Thriving Families
- Washington Communities for Children
- Within Reach State Chapter

Research/evaluation/technical assistance

- Chapin Hall
- Harvard Government Performance Lab
- State/Private universities

Strategies for supporting relationships across agencies and initiatives

States identified several key strategies for expanding and nurturing collaborative relationships across systems to foster prevention efforts, including:

- **Establishing multisystem taskforces, working groups, steering committees, and regular meetings between agencies** which includes partnerships from Departments of Early Childhood, Child Welfare, Home Visiting Coalitions, Offices of Mental Health, nonprofit organizations, parent advisory councils, and higher education institutions. These taskforces and working groups have allowed states to build long-lasting relationships that continue beyond one individual or team, promote systemic collaboration, and establish a collaborative culture within systems (CO, MI, NE, NY, SC, WA).

- **Stated commitment from state leadership** to invest in and value prevention as a top priority (CO, MI, NE, WA).

- **Being aware of, and pursuing, new federal funding streams** to expand prevention, including the Family First Act and Preschool Development/Preschool Development Birth through Five Grants (PDG) (NY, NE).

- **Building on existing local, state, or federal efforts** such as successful community-based pilot programs or initiatives like Thriving Families (CO, NE, NY, MI, SC).

- **Enacting legislation** requiring new prevention-focused services (NE, WA).

- **Developing data sharing infrastructures or data sharing practices** between partners that provide opportunities to track and assess prevention efforts and child outcomes; for example, tracking referrals and follow-up contact with families through a single point of entry data system (SC, WA).

- **Creating training tools, guides, resources, and toolkits** for partners to enhance staff awareness of the services offered by various agencies serving children, including eligibility criteria and referral processes, and to establish open lines of communication across partners (NE, NY, SC, WA).

State Perspective: New York

"Our data tells us a large percentage of the families that come to the attention of child welfare are for basic maltreatment [or what] most states call neglect without any associated abuse. So when you have many of the families needing this high-level intervention it tells us that we have to redesign and transform our system, which is what we're trying to do. So we are partnering differently internally, as well as with our sister-state agencies, to make sure we are supporting our communities and our families in a way that will reduce the need to call [child protective services] to find supports for families."

Challenges in establishing and supporting collaborative partnerships

States also noted challenges in collaboration. Even with a strong commitment to building cross-system partnerships, there are major challenges in working together to expand prevention efforts. Barriers identified by states are detailed below.

State perspective: Nebraska

"You can go fast, but if you're not taking the time to develop relationships with who you're working with, it will most likely fail, or you'll lose engagement. I heard this one time – someone drew a triangle and the three points were quality, speed, and quantity. They said, you can have two of these, but you can't have all three. You can have quality and you can have quantity, but it's not going to go fast. You can go fast and you can have quality, but you're not going to have very much of it. You can never have all three, and that has always been in the back of my mind."

It takes time and commitment at the leadership level to make change, and leaders face competing demands and priorities. Some states who engaged successfully in broad, collaborative prevention efforts noted delays in executing plans due to lack of "ownership" from a lead agency when agencies merge or partner in new ways (WA). Two states (CO, SC) also noted that there are no "quick fixes" to longstanding social problems such as child maltreatment, but there is pressure to demonstrate measurable outcomes of prevention investments quickly. More generally, several states commented on challenges associated with challenging the status quo, launching new programs or initiatives, and hesitancy to persevere with prevention when previous efforts were ineffective or did not yield results quickly enough.

Building the capacity of the workforce and a lack of services limits states' ability to implement prevention efforts. At a child-serving department level, leaders in prevention-focused departments thought that child welfare staff would benefit from additional training and support in identifying prevention programs, determining appropriate levels of care, and referring families. Several states (NE, NY, SC) also highlighted chronic workforce shortages, particularly in the mental health and substance use space, as well as disparities in access to programs in rural communities. At a child welfare system level, county-administered states discussed challenges to consistently implementing prevention activities statewide. Four states described varying service availability across regions of the state (CO, NY, SC, WA). Even with strong partnerships and funding, ensuring equitable access to programs, providers, and services often poses a challenge to prevention implementation, particularly in rural, frontier, and Tribal communities.

It takes time to understand and learn how to leverage the role and expertise of new agency partners. Some states commented on a general lack of awareness by other systems that child welfare is "relevant" to their population (e.g., K-12 education, state departments of education), which can stymie collaboration. For example, state child welfare administrators recalled unsuccessful attempts to collaborate with education agencies through programming or collaborative groups. Administrators attributed this lack of engagement

to limited awareness that a significant portion of students in K-12 schools are at some point involved in child welfare and may benefit from specialized programming and supports; relatedly, schools may not know when students are involved in child welfare due to confidentiality requirements. As discussed in more detail in **Key Finding 3**, other state agencies noted challenges partnering with child welfare on prevention efforts due to stigma around child welfare in many communities, particularly communities of color, and a lack of capacity in the child welfare workforce.

States leverage different constellations of funding sources, but no state has adequate funding to meet all the needs of families and communities.

Prevention work is heavily supported by the funding that states receive to support service delivery and implementation like parenting, mental health, substance use, and kinship navigator services. States identified that it is necessary to tap into a wide variety of funding sources to meet the needs of families, with no single funding source being adequate. Dozens of funding sources were discussed throughout the interviews. Sources range from federal dollars (including Title IV-E of the Social Security Act, Maternal, Infant, and Early Childhood Home Visiting [MIECHV], Substance Abuse and Mental Health Services Administration [SAMHSA], PDG, Family First Transition Act [FFTA], Children's Bureau grants, Child Abuse Prevention and Treatment Act [CAPTA], American Rescue Plan Act [ARPA], Child Care and Development Fund [CCDF]); state dollars (such as through state taxes, domestic violence programs, designated governor's office funding); Tribal funds; and private or philanthropic support (including both national and local foundations). Some of these sources are specific to child welfare (such as Title IV-E and CAPTA), others have a much broader/more flexible scope (such as Temporary Assistance for Needy Families [TANF], ARPA), and others are specific to other systems that consider their work as a part of the prevention array (CCDF, PDG).

Common sources for funding direct services and staffing supports include Community Based Child Abuse Prevention (CBCAP), CAPTA, TANF, Medicaid, Title IV-E, and ARPA. For example, states described using ARPA, CAPTA, and Medicaid dollars to build up front-end service needs, technical assistance support for prevention referrals, supporting Strengthening Families work, providing concrete supports to families, and substance use prevention efforts. All states discussed the importance of MIECHV funding to support home visiting programs and state coalition building efforts that uplift much of the collaboration and coordination strategies happening. Other opportunities, like PDG, CCDF, Community Mental Health Services Block Grant (MHBG), and Tony Grampsas Youth Services, were noted as funding streams specifically tailored to prevention work upstream within early childhood spaces or prevention work broadly.

State perspective: Washington

"I think another challenge is funding. Sometimes we have too much. Or too little. Or too restricted. Sometimes we have too much funding – we can't get it out the door because we've got too much in a pot and it's hard to get it out because the contracting process is hard. Sometimes there's too little, and I could definitely see that from a community perspective. There's too little that's going to communities. It's too little going to families. And sometimes our funding has so many strings attached - like we can't do this, or we can't do that. So it's funding, but it's not just that it's scarce, it's just that it's challenging."

While all six states are using creative braiding (i.e., coordinating two or more funding streams to support a full program) and blending (i.e., wrapping two or more funding streams to fund specific program aspects) strategies to fund prevention services, each state described the same two key barriers to sustainable, direct funding for prevention:

- **There is never enough funding to develop and sustain the innovative work states want to do.** All states noted that there is not enough funding available for prevention work, particularly as funds trickle down to local community agencies providing services. For example, despite state agencies having state and federal funding for prevention, policymakers and funders want evidence of

positive outcomes tied to prevention funding, which is difficult to provide in the short-term. This desire for short-term demonstration of positive outcomes can reduce motivation of funding agencies and state legislatures to invest in capacity building for the workforce or innovative pilot programs.

- **Funding is not flexible enough to support the types of prevention programs states envision.** Most states noted that state and federal dollars often come with various eligibility criteria and requirements for reimbursement and draw downs, requiring laborious management or administrative capacity. Most states discussed how these "strings" require government staff time, reducing the amount of funding for services that reach families.

All states have blended and braided dollars between various systems, including child welfare, early childhood, and health agencies to support widespread prevention work across sectors. States described this strategy of blending and braiding as important and essential to sustaining prevention services long-term, noting that blending and braiding can manage shifts in funding availability by agencies and organizations over time. Relatedly, states noted that blending and braiding efforts can also be complex and difficult without dedicated, knowledgeable staff. Funding challenges can make it particularly hard for states to try innovative prevention programs and/or community-based prevention initiatives. When able, states braid and blend together federal, federal passthrough, and state dollars, as well as philanthropic funds, to fund prevention.

Financing examples from states

Although states utilize common sources and strategies to fund prevention, the fiscal landscape for each state is unique. Below, we share some unique and innovative financing strategies from each of the six states.

Colorado, with a county-administered child welfare system, brings a strong investment in local dollars, combined with state and federal funding. The state has a general budget line item to support family preservation, which is the largest non-federal funding source available to counties for prevention services. Counties have a lot of flexibility in what efforts they choose to include in their prevention initiatives. Colorado also has the Tony Grampsas Youth Services Program, a state-funded grant program that provides funds to community-based organizations.

Michigan places a high priority on prevention, with the state blending and braiding multiple funding sources. In its service delivery efforts, the state aims to ensure families have a seamless and simple process for accessing services, and state administrators work behind the scenes to determine the appropriate funding source. The state has also creatively used time-limited COVID recovery funds (ARPA) to provide technical assistance for prevention staff, to build up front-end services (e.g., for implementing plans of safe care), and provide more access to child care subsidies. Children Trust Michigan is also an important partner in the state – helping to raise funds that are dispersed into partners across the state to support prevention efforts.

As in other states, **Nebraska** engages in blending and braiding federal and state funds, including CAPTA, MIECHV, PDG, CCDF, Medicaid, Title IV-E, and state dollars. The state credits strategic leadership that prioritizes prevention – specifically through its Strategic Transformation Initiative – with supporting good fiscal collaboration. Bring Up Nebraska, run by the Nebraska Children and Families Foundation with collaborative partners in the public and private sectors, helps coordinate services and bring funding to communities so community partners can help families connect with the services they need. Additionally, as a Thriving Families, Safer Children site, the state has been able to leverage new funding opportunities and raise awareness about prevention across the state.

Although state and federal funds provide the core funding for prevention efforts, **New York** leverages philanthropic funds for innovative or pilot programs. New York also has strong partnerships between

agencies that can help enhance or expand programming around specific goals. For example, to expand available substance use services, the state works with multiple partners and leverages different funding sources to meet the needs of communities. They are working on a new partnership between the Office of Children and Family Services and the Office of Addiction Services and Supports to braid together Medicaid and child welfare funds to provide additional substance use services to families. They are also leveraging CAPTA funds in four districts to hire prevention staff to support families experiencing substance use challenges.

In order to provide primary, secondary, and tertiary prevention services to families, **South Carolina** leverages funding from a variety of state, federal, and private sources, each with their own narrow requirements. For example, South Carolina relies mainly on the state's Department of Social Services to support primary prevention programs via funding to community providers, while Family First Act dollars primarily fund secondary prevention services. The state has a diverse set of funders supporting home visiting efforts, including MIECHV, Medicaid, the federal Children's Bureau, and the Duke Endowment. Although it does tap into additional funding sources, including PDG (which funds the state's Early Childhood Advisory Council), SAMHSA, Title IV-E, and CAPTA, those funds are limited. State funding is the most sustainable source of prevention funding in South Carolina.

Washington has established unique connections and funding priorities for prevention, including a push toward more culturally relevant services (e.g., services designed specifically for Indigenous communities) and concrete supports (e.g., guaranteed basic income) for families and children. CAPTA, CBCAP, Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), PDG, and MHGB dollars are all utilized with specific target areas. For example, ARPA dollars supported concrete supports and MHBG dollars were essential to moving prevention work upstream. Philanthropic partners, like the Bezos and Gates Foundations, have contributed to the push toward providing more concrete supports to families, with pilot programs providing guaranteed basic income to families. Washington leveraged FFTA funding to support culturally responsive programs that have been well received by communities, and has proposals submitted to legislature to include more money for long-term sustainable funding for culturally relevant services. Washington has also established Medicaid 115 waivers to pay Tribal inpatient substance use disorder providers more than non-Tribal providers to support this need.

Key finding 2: States have an innovative range of services that are designed to meet the unique needs of families with young children; however, they are not available in every state or county/region within states.

As described above, states' visions for prevention include services at the primary, secondary, and tertiary levels. Many of the interviewed states credit more robust investments in primary prevention services to a better understanding of the factors that are associated with maltreatment, including parent-child relationship quality, mental health, maternal health, poverty, and historical racial and ethnic inequities in service access. This includes an increased focus on meeting the unique needs of infants and toddlers and their families to reduce child welfare system entry or reentry. Throughout this section, we share state efforts to specifically serve young children and their families, and some of the challenges in doing so.

States are investing in prevention services that are specific to young children and their families.

Although not universally available in each state, states shared details on an array of unique supports for infants and toddlers:

Home visiting programs and coalitions. Across all states, home visiting is laying the groundwork for expanding prevention efforts and increasing cross-agency coordination efforts across early childhood serving systems (e.g., early learning, state departments of early childhood, child welfare, public health). All states discussed home visiting as one of the key strategies for delivering primary prevention services to young children and their families, with all states including home visiting in their Family First Act Prevention Plans. However, there have been challenges with incorporating home visiting into child welfare agencies or accessing Title IV-E prevention dollars for home visiting services: Some states (SC, NY) report that child welfare agencies are not fully aware of the services home visiting provides and how they may benefit families involved in child welfare, how to refer families, and when it might be indicated to do so. Similarly, home visiting programs do not have consistent protocols or procedures in place to engage and coordinate with child welfare staff. Similarly, not all home visiting programs are available in every county or region of a state, creating variability in access to this important prevention resource as some families are not able to access home visiting at all, or access the model that would be most useful to them.

State perspective: Colorado

"I would say 15 years ago that early childhood probably only meant childcare or early childhood learning. now that's definitely not the case that the field embraces not only the teachers but also home visitors, early intervention providers, early childhood mental health consultants, family advocates, it's a much broader definition for the system, the workforce, and services."

Infant and early childhood mental health programs. All states discussed their efforts to expand infant and early childhood mental health (IECMH) and social-emotional supports and services for young children and their families, many of which are coordinated through state infant mental health associations. These efforts included applying for grant funding for IECMH endorsement (MI, SC). Other states are focusing on expanding training and implementation of IECMH consultation (CO, NY, WA) and social-emotional curricula for child care educators (e.g., Pyramid Model; NE). Most states (MI, NE, NY, SC) highlighted limited access to IECMH services and mental health workforce shortages as a barrier to implementing prevention practices, and that these shortages disproportionately impact families living in rural and frontier areas, in particular.

State perspective: Colorado

"It's really difficult for us to find skilled people who come into our office all trained and ready to work with 0-3 [year olds]. That takes skill. That takes someone who is actually trained. It takes money. We can't just bring a counselor and say work with infants. It takes money and training."

Early childhood services. Washington and South Carolina are using coordinated resource and referral networks that incorporate infant- and toddler-specific programming (e.g., Help Me Grow in WA or the SCparents.org portal), but these networks can only refer families to services if those services exist in their communities. Families in rural and frontier areas experience significant gaps and disparities in the availability of services compared to urban and suburban communities. These states consider early childhood education efforts (e.g., PDG, investments in child care) to be prevention mechanisms.

Plans of Safe Care and other parental substance use efforts. Multiple states (MI, NE, SC, WA) have initiatives related to infants with substance exposure and implementation of their state Plans of Safe Care (POSC). For example, in South Carolina, Medicaid eligibility for substance use treatment was expanded to 12 months postpartum to evaluate whether expansion translated to positive outcomes for infants and parents. Agencies that provide services to children and families are aware that children aged zero to three are most at risk for child welfare involvement, often due to parental substance use, and several initiatives and pilots focus on newborn infants exposed to substances. Some states (MI, NE, WA) are exploring prenatal POSC initiatives to reduce stigma from services providers for pregnant parents and inappropriate investigations by child protection.

Infant-Toddler Court teams. All of the states in this study have implemented ITC teams. ITC teams, an approach designed by ZERO TO THREE, aim to support states and communities in building a more coordinated and aligned early childhood system. The approach works concurrently at the child and family level, community level, and state level to promote healthy early childhood development while impacting long-term system capacity building. The goal is to keep families together by igniting collective action on the part of the entire team to meet the urgent needs of infants, toddlers, and their families. While the ITC team approach is anchored in the court system, it is an entry point for cross-system collaboration to effectively serve families across multiple areas of need at the state, local, and individual family levels.

Parent Perspective

"We need protective measures in place and a place to live, they need to be at the top of the list, just as much as they're honoring fleeing a domestic violence or intimate partner violence situation. Giving voice to that is crucial. If your immediate needs aren't met, you'll always be in survival mode or crisis, you can't dive deeper and look at what kind of parent you're going to be long term. There is value in services that would allow us to learn about ourselves as a person, as a parent, and about our child."

Cross-agency collaboration is uniquely important for cohesive prevention systems for young children.

In addition to programs designed to meet the unique needs of infants and toddlers and their families, states also highlighted cross-agency collaboration as particularly important for families with young children because of their connections to early childhood systems. Cross-agency collaboration allows services and systems to engage holistically with families using a primary prevention lens. For instance, South Carolina discussed the importance of intentionally developing a holistic service array that provides families with wraparound supports to promote family stabilization and reunification; they noted that using this type of approach requires more flexibility in how services are selected, implemented, and funded; that is, expanding the vision beyond a narrow set of evidence-based programs to thinking about concrete needs and supports for families with young children. The state developed a birth through five state plan and a single portal and eligibility screener for families with children aged 0-5 statewide, through First 5 South Carolina.

Alignment between prevention efforts and child care stabilization is also important. Several states discussed a need for more accessible child care for young children, particularly those at risk for or involved in the child welfare system. Some states highlighted their successes and opportunities around expanding child care access. In South Carolina, First Steps allows families to apply for child care directly at the Department of Social Services office or through 2-1-1 using a voucher program. In New York, the governor announced that affordable, accessible child care is a state priority, and as a result, expanded income eligibility for families, made child care applications available online, and implemented compensation initiatives for the child care workforce to increase caregiver retention.

Although these strategies specific to young children exist in some states, the challenges around collaborating discussed above also apply to collaboration between early childhood agencies and child welfare initiatives broadly.

There are challenges in accessing services designed to support families with young children.

Despite these advances in infant/toddler-focused prevention, many infant/toddler services and programs exist in pockets and are not universally available in all states interviewed or in all regions within a state. Challenges in service delivery for infants and toddlers mirror challenges to maltreatment prevention generally, including limited accessibility for rural and frontier areas, limited workforce capacity and training, limited culturally responsive models and services, and lack of dedicated, flexible funding streams. As discussed above, the financing challenges facing states generally are also a challenge for these services. All states commented on workforce shortages, particularly in mental health and substance use services; even when funding is available for programs, there is not always a workforce ready to be trained in and to implement evidence-based programs.

Parent perspective

"A barrier is accessibility to treatment…People can be waiting 2 or 3 months for evaluations, and that's preventing reunification. We really need to get engaged immediately in treatment, not sitting around getting used to our children not being in our care. I'm trying to advocate for parents to get into treatment as soon as possible… "

"We have very limited inpatient treatment, especially that you can bring your kids to. Our main referral source doesn't have inpatient treatment, they're automatically putting people on an outpatient level so many people aren't getting what they need. Even if a parent says they need inpatient there isn't anything for them and they're not referring them to outside agencies. Honestly, the luck of getting into someplace is very slim as well."

Key finding 3: Each state is working to promote equity and incorporate parent voice in their prevention planning and implementation.

States are centering equity in their prevention efforts.

States identified that partnership, trust, and relationship building are key to ensuring that families feel comfortable accessing preventative services and supports from every available agency. Systemic racism; historical inequality; and disproportionality in child welfare system processes and outcomes, including representation across race, ethnicity, income, and health status, have contributed to longstanding distrust between families and state agencies, specifically agencies that house child protective services, as well as relationships between federal child welfare system, Tribal governments, and Indigenous people. States identified that they must be intentional in taking steps to undo the systems and structures in place that contribute to overrepresentation of Black, Hispanic, and Indigenous families, families living in poverty, and

State perspective: Nebraska

"Even if I'm the nicest person and my title is the prevention administrator, I'm still with [Children and Family Services]. If I'm the one reaching out to families and communities, it still feels like it's [Child Protective Services]. It's helpful for us to have another collaborative agency that can reach out and be the voice, knowing that we can be there for support. It's important to me that families don't think they're continually under surveillance, and they can be vulnerable and open to asking for help when they need it without having to come to the department."

families with unmet health and behavioral health needs in the child welfare system, which prevent them from participating in preventative programming that can support family well-being and preservation.

States are considering multiple ways of defining equity, including on the basis of race, ethnicity, income, and health status, as they work to create strategies to reduce disproportionalities that exist in their jurisdictions. While equity challenges related to housing and food access; limited access to services provided in native languages; and an overrepresentation of Black, Hispanic, and Indigenous families in the child welfare system were flagged by states, the two leading equity drivers highlighted in discussions were racial and geographical equity, with a focus on ensuring equitable access to services ("race and place" related challenges).

States described several key strategies and practices that they found successful for centering equity in their prevention work, emphasizing that equity should be integrated with prevention work throughout the process:

- **Conducting a needs or readiness assessment** at the community and/or state level to ensure an accurate understanding of the landscape of the state, the people that compose it, and their unique strengths and needs when beginning equity-driven work. For example, Washington described plans to conduct a landscape analysis of culturally relevant/adapted services.
- **Building equity into strategic plans and state budgets** to demonstrate importance and ensure that equity-focused work can be actualized. Having equity explicitly named and budgeted for has helped support staff in understanding its prioritization and ensures accountability from year-to-year, despite staff turnover or transitions in leadership. For example, Colorado allocated ARPA funds specifically to enhance and expand diversity, equity, and inclusion efforts, and Washington has a Strategic and Racial Equity Plan to guide its priorities.
- **Establishing working groups and steering committees** across agencies, organizations, and sectors with a diverse group of stakeholders – including those with lived expertise -- that are specifically tasked to promote equity-related work. These cross-sector groups encourage collaboration, foster a shared sense of responsibility, and ensure energy and efforts are not incomplete or siloed, with power to affect change. For example, Michigan's Child Welfare Improvement Task Force brings together cross-sector partners and individuals with lived expertise to focus on addressing the disproportionate representation of children of color in the child welfare system.
- **Creating training tools, guides, resources, and toolkits** for staff, leadership, and partners to utilize and leverage in their everyday work. Trainings and resources have been made available in multiple languages and promote bias reduction and culturally responsive engagement with families. For example, New York has a race equity training for caseworkers and service providers to ensure equity is centered in all of their work with families.
- **Building trust with families and communities that have historically been or continue to be marginalized** by hiring staff and providers that mirror the communities they are serving and equipping staff with training on family engagement in a culturally responsive way. Prioritizing workforce representation, and the hiring of individuals with lived experiences with the child welfare system, especially for staff directly interfacing with families, is helpful in building positive relationships and dismantling negative perceptions about the priorities of agency departments and staff. It has also been helpful for agency staff to go directly into communities to connect with families, promote prevention services and supports, and utilize stakeholders or trusted persons in a community to facilitate relationship building. Trusted voices and leaders in the community have been included in decision-making and serve as liaisons between agencies and communities, and states should compensate these individuals for their efforts. As one example, South Carolina's child welfare agency has created a Community Trust Liaison position to build relationships and trust, and increase transparency with community partners.

Partnering with Tribes

Three states (MI, NE, WA) also shared some unique strategies specifically for working with Tribes:

- **Consulting with Tribes in a government-to-government way** and be proactive in their engagement with Tribal leadership. States described the importance of including Tribes in state planning and meeting routinely and frequently with Tribes to ensure strong and open communication.
- **Creating a department, team, or set of staff** dedicated supporting Tribal relations. Some states have prioritized recruiting and hiring staff who are also Tribal members, or have existing connections to Tribes, who served as liaisons between the state and Tribes to facilitate trust building.
- **Establishing Tribal advisory and working groups** across state departments. States described including Indigenous families as members of advisory and working groups and, as described further below, indicated the importance of compensating families for their expertise and time.
- **Offering supports and funding** to Tribes based on what Tribes define as their priorities and needs. States are working with Tribes to understand the services and supports that Tribes want to provide to their community and should offer technical assistance and aid when requested by Tribal leaders.

State perspective: Washington

"Build the relationship with Tribes…Really understand what it means to work on a government to government relationship, to not treat tribes as stakeholders. The process and the relationship is not the same as a stakeholder. Tribes are sovereign nations. Early engagement with Tribes, as well. When I review legislation, I'm looking at Tribal impact and am thinking also about inviting Tribes into the conversations early on so they're not an afterthought. I'm looking to bring [state] leadership into the advisory structures when working with Tribes. Have a presence."

Facilitators to centering equity in prevention efforts

Each state identified facilitators that can support the prioritization of equity across different systems and partners. States emphasized the importance of amplifying individual communities and their needs when embarking on equity-driven work, understanding that each community has different demographics, goals, and needs. While collecting and analyzing data at the community level is key to ensuring that the services designed and implemented are appropriate for the families that they are aiming to serve, states also shared the importance of letting communities themselves determine and lead the prevention work being done in their locality.

Challenges in centering equity in prevention efforts

Each state identified barriers to advancing and promoting equity. All states noted specific challenges related to service access based on geographic location. Rural and frontier communities lack access to many prevention and health care services as a result of a lack of funding and available providers (e.g., lack of home visiting services in communities not eligible for Maternal, Infant & Early Childhood Home Visiting Program [MIECHV] funding). These rural and frontier areas are commonly where states identify the greatest levels of disparity, and while service gaps continue to exist, states are prioritizing the creation of new initiatives in these regions.

In addition to provider and service availability, states shared that there is a lack of culturally appropriate and responsive evidence-based practices (EBPs) available that meet the needs of their communities, both

generally and within the Family First Act Clearinghouse. States noted that many EBPs were developed for, and evaluated with, samples that predominately included White participants, and some services already being implemented by states with more diverse racial and ethnic representation are not classified as EBPs, despite successful community implementation and uptake. States with sizeable Tribal populations, in particular, need to partner with Tribes to understand the services they need and want and complete evidentiary reviews to get non-qualifying services qualified as evidence-based, which can be costly.

Barriers and challenges in forming strong partnerships with Tribes

During our interviews with states, they shared several factors that have hindered strong partnerships between state agencies and Tribal Nations and communities around prevention efforts. These challenges included:

- **Limited state awareness and resources on engaging Tribal communities that align with existing capacity and resources.** For example, states may have specific funding designated to Tribal communities, but may lack awareness of Tribal community capacity to apply funding with complex limitations and "strings" attached. Tribes may also have limited capacity to launch new programs or expand services without adequate implementation supports. States reported needing more resources and understanding related to how to partner with Tribal communities in a way that aligns with Tribal capacity and resources.
- **Engagement is limited by unique and specific administrative reporting and documentation requirements for Tribal Title IV-E agencies.** For example, Nebraska noted that while there are Title IV-E agreements with each of the Tribal communities in the state, there are administrative barriers to service implementation that exist for Tribes but are nonexistent at the state level. This impacts active participation in Tribal related programs, contributing to limited coordination opportunities and relationship building between states and Tribes.
- **Staff turnover rates, in both state and Tribal leadership, hinder sustainable relationship building and communication.** States recognized that relationship building needed for coordination requires sustainable relationships and communication between individuals and governments. With staff turnover in Tribal liaison positions in state offices and limited state understanding of Tribal governance (e.g., term limits and changes in Tribal leadership), establishing long-term relationships can be challenging. States reported that there are also natural shifts in Tribal leadership as tribes elect new leaders with unique priorities who bring in their own staffs.
- **As discussed in more detail in Key Finding 4, there are limited number of culturally responsive programs and service array models that qualify for Family First Funding, which creates barriers to authentic partnership with Tribal communities**. State and Tribal liaisons recognized that limited offerings of culturally responsive practices – in the Family First Clearinghouse and more broadly – for Indigenous families and communities discourage Tribal buy-in to partnerships, because often, services may not be appropriate, relevant, or generally meet the needs of Indigenous communities. There is a limited array of federal Clearinghouse programs that are culturally responsive or aligned with the current needs and experiences of Tribal communities and their ongoing prevention efforts.

To support more equitable child welfare and prevention systems, states are striving to incorporate family voices into their policymaking and practice.

Each of the states involved families in designing their prevention strategies in some way, and all states also identified opportunities to increase that engagement. States shared their goals for enhancing their work in this area. Family engagement opportunities ranged from more transactional activities (e.g., data collection) to advisory roles and opportunities for shared decision-making.

State spotlight: Colorado

In Colorado, funding received through the American Rescue Plan Act (ARPA) was slated to expand and enhance diversity, equity, and inclusion efforts throughout state. Colorado, with priorities of reaching rural and frontier communities, and engaging those with lived expertise in their work, used a myriad of strategies with their funding to ensure that they were doing work that is meaningful and beneficial to the communities being served. Among other strategies, Colorado provided funding directly to communities so they could identify their biggest needs and have the supports (e.g., funding and technical assistance) needed to carry out the work they identified as priority. Funding was also provided to create a Family Voice Council and to engage with youth at the local level, with the hope of lifting up the voices of those with lived expertise and ensuring that the work being completed and policies being enacted did not have any unintended consequences.

State perspective: Michigan

"We need to make sure that we have a family-led system, and that families, parents, and guardians are at the table and we can design a system to meet their needs. We want to focus on the root causes of needs and using that root cause as a systematic conversation facilitated by the whole community to achieve our goals with culturally relevant strategies and an action plan. The funding comes. If there is a need, we'll find the dollars."

Most commonly, states engaged families in prevention planning through a **structured committee or advisory councils.** These groups have been convened by state agencies and nonprofit organizations across the child welfare, home visiting, early learning, judicial, and substance use fields. These committees and councils engage a range of different perspectives, including parents (both with and without lived experience in the child welfare system), foster parents, kinship caregivers, adoptive parents, and young people with lived experience in foster care. Many of these groups have charges that extend beyond prevention planning, and states consulted with them on specific topics as they arose. For example, Michigan's Department of Health and Human Services' Guy Thompson Parent Advisory Group provides input on policy and practice across a range of child welfare issues and was consulted specifically on developing training modules for the state's Plans of Safe Care, as well as the script and protocol for a pilot prevention program in which 2-1-1 reaches out to screened out families to offer supports.

Other committees were formed specifically to guide prevention planning and include a mix of individuals with professional and lived expertise working together to make decisions and guide their work. For example, approximately half of the members of South Carolina's Thriving Families Steering Committee bring lived expertise to their work to develop prevention approaches in four counties, with active involvement from planning through implementation. In two instances, parent representation on an advisory council is required in statute (Washington's Early Learning Advisory Council and South Carolina's First Steps boards).

Additional engagement strategies were used by states, and illustrative examples of each strategy include:

- **Family-driven service planning,** which sometimes includes **peer support services**, is a focus in four states (CO, NE, SC, WA). Nebraska has implemented Safety Organized Practice, which emphasizes

family voice in case planning. In the parent focus group, parents noted they found significant value in peer support activities, both to support specific families and to advocate for systems change from the ground up.

- **Data collection efforts** allowed four states (CO, MI, SC, WA) to elicit input on prevention planning through surveys, focus groups, listening sessions, and interviews. For example, Washington uses the Sense Marker Survey, which is administered by parents, Tribal elders, and other culturally relevant leaders, to gather stories from community members with the goal of strengthening community-based supports. South Carolina engaged over 5,000 individuals through surveys and focus groups across all counties to inform the state's Birth through Five Plan.

- **Individuals with lived expertise delivered staff trainings and conference sessions** in two states (NE, WA), including a summit on authentic engagement at the Nebraska Court Improvement Project's Children's Summit.

    - Parent engagement in legislative advocacy (WA).
    - Parents serving on hiring committees and reviewing applications for prevention funding through the Community Based Child Abuse Prevention (CBCAP) program in Washington.

State leaders noted several factors that have helped them expand and nurture their family engagement efforts. Five states (CO, NE, NY, SC, WA) underscored the value of having designated staff members responsible for family engagement, and in three states (NE, NY, SC), staff bring their own lived expertise to their work. For example, the Family Advocacy Unit within Nebraska's Department of Health and Human Services is staffed by individuals with lived expertise in the child welfare and/or juvenile justice systems. Providing financial compensation and/or child care facilitated family engagement in three states (CO, NE, WA). Following a statutory change to ensure that families could be paid for their time, Washington issued statewide guidance on compensation for individuals with lived expertise. While compensating families for participating in program planning and decision-making is valued by states, they also recognized that families claiming this additional compensation on their tax returns can negatively impact their eligibility for other benefits.

Two states (CO, NE) described receiving technical assistance and participating in learning communities to enhance their family engagement strategies. Finally, states described the importance of simplifying application processes, creating opportunities for parents to lead conversations, being mindful of power differentials, and building on existing mechanisms for family engagement (e.g., existing committees or parent groups/programs), rather than creating new processes.

State perspective: Colorado

"I think, number one, fundamentally, this understanding that you can't do prevention, and more importantly family strengthening, without working across communities and systems. So if you don't know your early childhood leaders or the public health leaders, if you don't know your healthcare or housing leaders, that's the only place to start. Collectively is the only way we can do this work. And secondly, don't go anywhere, don't start down any path, before you get families at the table. You have to start with families at the table, not bringing them in later."

Each state identified barriers they face in further developing their family engagement strategies. Without consistent, ongoing engagement and feedback loops, states described some of their efforts as transactional, with the potential for tokenizing families as "afterthoughts" rather than authentic partners throughout all stages of decision-making. Further, without a clearly defined purpose for parent/caregiver participation and corresponding action steps, families may disengage from committees or groups. Three states (MI, NE, SC) identified specific gaps in their work that they hoped to address (e.g., engaging family members in multidisciplinary teams, including young people in prevention efforts), while two states (CO, WA) identified a broader need for staff and partner trainings on parent engagement strategies.

Key finding 4: While the Family First Act plays a unique and important role in overall prevention efforts, states report implementation challenges.

All of the six states in this study have Family First Act Prevention Plans that have been approved by the federal Children's Bureau.[6] The plans detail the services that will be provided and the families who are eligible for services based on the state's definition of a "candidate for foster care."

Family First Prevention Services Act (Family First Act) of 2018 allows states to draw down federal Title IV-E funding for services to prevent children from entering foster care, provided the state and the services meet specific requirements. Parenting, mental health, substance use, and kinship navigator services are eligible for federal reimbursement if the service model is rated as promising, supported, or well-supported on the Title IV-E Prevention Services Clearinghouse (Clearinghouse). Among other requirements, states must submit data on the families served through this funding stream. States also received funding through the Family First Transition Act (FFTA), as part of the Further Consolidated Appropriations Act of 2020, to support implementation.

While children ages 0-3 account for 34 percent of child maltreatment victims nationally (see Table 1 for states in this study),[xv] only two states have explicitly identified specific groups of young children in their candidacy definitions:

- Infants born with substance exposure are candidates in Michigan, and
- Children receiving home visiting services through Healthy Families New York are candidates in New York.

Two states (MI, SC) also identify families with children ages 0-5 as priority populations in their Prevention Plans, which helped guide Michigan's selection of programs. Additionally, all six states include pregnant and parenting foster youth and their children in their Prevention Plans, opening prevention services to young parents and their children.

In their Prevention Plans, states include a variety of programs specifically for families with young children, including home visiting programs (e.g., Parents as Teachers, Healthy Families America, SafeCare) and mental health programs (e.g., Child-Parent Psychotherapy, Parent-Child Interaction Therapy). The table below summarizes candidacy definitions and early childhood services from each participating state's Prevention Plan.

State perspective: Michigan

"I want to be in primary prevention space. I want to figure out how we can use Family First dollars to do that primary work, make sure that families have choice so that we can shift the child welfare system to be more prevention focused rather than risk focused."

[6] Plan approval dates range from October 2020 to September 2022, with each state at a different stage of implementation.

Table 2. State Title IV-E Prevention Program Five Year Plans Details

State	Prevention Plan and date[xvi]	Definition of candidate for foster care for Family First Act-funded services (relevant to infants and toddlers; for full definition, see state plan)	Interventions for families with infants and toddlers included in Prevention Plan[7]
Colorado (CO)	Colorado Five-Year Family First Prevention Services Plan (Approved 9/2022[xvii])	Identifies an intentionally broad definition of candidate that includes several circumstances and characteristics of children and families. Taking a phased implementation approach, with the initial definition of candidates including only those children and youth with an open child welfare case or juvenile justice involvement. Expectant and parenting foster youth are considered candidates. No other criteria focus specifically on families with infants and toddlers.	• Child First • Healthy Families America • Nurse-Family Partnership • Parent-Child Interaction Therapy • Parents as Teachers • SafeCare
Michigan (MI)	Michigan Title IV-E Prevention Plan (Approved 7/2022)	Describes eight populations considered to be candidates for foster care, including infants born with substance exposure and the child of a parent who was in foster care (until the parent reaches age 26). Families with children under six and pregnant/parenting foster youth are priority populations.	• Family Spirit • Healthy Families America • Homebuilders • Motivational Interviewing • Nurse-Family Partnership • Parents as Teachers • SafeCare
Nebraska (NE)	Nebraska's Five-Year Title IV-E Prevention Program Plan 2020 (3rd Edition) (Approved 2/2020)	Identifies several populations, including pre- or post-natal infants of pregnant or parenting foster youth, as candidates for foster care.	• Family Centered Treatment • Healthy Families America • Homebuilders • Motivational Interviewing • Parent-Child Interaction Therapy • Parents as Teachers

[7] Several states list prevention programs funded through other sources in their Family First Prevention Services Plans. This table includes only those programs explicitly identified as being funded through FFPSA.

State	Prevention Plan and date[xvi]	Definition of candidate for foster care for Family First Act-funded services (relevant to infants and toddlers; for full definition, see state plan)	Interventions for families with infants and toddlers included in Prevention Plan[7]
New York (NY)	New York State Family First Prevention Services Act Prevention Plan (Approved 8/2022[xviii])	Will phase in expanded definitions of candidates over time. The initial wave includes pregnant and parenting youth in foster care, children with an open prevention case, and children receiving home visiting services through Healthy Families New York.	• Family Check Up • Healthy Families America • Homebuilders • Motivational Interviewing • Nurse-Family Partnership • Parent-Child Interaction Therapy • Parents as Teachers
South Carolina (SC)	South Carolina's Title IV-E Prevention Plan (Approved 1/2022[xix])	Includes pregnant and parenting foster youth and children and families experiencing a number of different risk factors. Children ages 0-5 are a target population.	• Healthy Families America • Homebuilders • Nurse-Family Partnership • Parent-Child Interaction Therapy • Parents as Teachers
Washington (WA)	Washington's Family First Prevention Services Prevention Plan (Approved 10/2020[xx])	Identifies eight populations considered to be candidates for foster care, including pregnant women who use substances, pregnant or parenting foster youth, and pregnant or parenting youth in juvenile rehabilitation.	• Child-Parent Psychotherapy • Homebuilders • Motivational Interviewing • Nurse-Family Partnership • Parents as Teachers • SafeCare • Triple P

State perspective: Washington

"I just wish we had more services, more service providers, and that there were more flexibilities in that service array. I think FFPSA [Family First Prevention Services Act] - when I think about those initial conversations that we had all across our state of like 'what do you dream with the implementation, what do you hope' - the things people talked about were more community driven responses, and FFPSA is very rigid and that feels very disappointing in a lot of ways. There are a lot of great services that aren't on that list. And so how do we build a structure that we can pay for those with that funding source, but that we open up this wider service array so we capture more families in different ways?"

The Family First Act is just one part of states' broader prevention strategies.

As described above, all six states situated the Family First Act within the context of their states' larger prevention efforts. States view these broader approaches as necessary to reach primary and secondary prevention (noting that the requirement that candidates for foster care be at imminent risk of removal creates narrow eligibility for Family First) and to allow for greater pathways to prevention services outside of the child welfare system. As the Title IV-E entity in each state, the child welfare agency is responsible for claiming Title IV-E funding under Family First. Title IV-E is the "payer of last resort" for prevention services implemented under Family First, meaning that if another funding source (e.g., Medicaid) would cover the service, they are responsible for payment before the Title IV-E agency.

Given the Family First Act's requirement that children be at imminent risk of removal to foster care to qualify for services, most respondents described the Family First Act as supporting their states' tertiary or secondary prevention efforts. While Colorado, for example, intentionally defined candidates for foster care broadly, the state plans to begin this process by only drawing down Title IV-E funds through the Family First Act for children and youth with an open child welfare case. Generally, the states' Prevention Plans often reference services that will be funded through other sources, illustrating their commitment to taking a broader and more upstream primary prevention approach. New York described the Family First Act as an opportunity to move further upstream in its prevention efforts, with one agency administrator explaining: *"although Family First is focused on tertiary work, we are focused on moving our services further upstream using Family First and prevention in all efforts to really reduce the need for CPS [Child Protective Services] intervention for those families that really need basic economic and concrete supports."*

Three states (NY, SC, WA) also described the importance of a broader approach to prevention that includes referral and connection to services through pathways other than the child welfare system. Recognizing that many families feel stigmatized by and lack trust in the child welfare system, New York described efforts to rebrand its child welfare agency, South Carolina described the value in delivering some prevention services outside of the child welfare agency's auspices, and Washington is exploring ways to connect families to Title IV-E-funded prevention services that would not require an open child welfare case (e.g., by offering service navigation services to families who are screened out by the hotline).

One of the tensions shared by states with this multipronged approach, which engages partners across systems, is a lack of clarity around prevention terminology. For example, while child welfare professionals may conceptualize keeping children out of foster care as prevention under the Family First Act, home visiting professionals are more likely to define prevention as preventing any contact with the child welfare system. Respondents pointed to the importance of having shared definitions and understanding of the different levels of prevention, explaining that this will help partners better coordinate, identify new partners, and ensure families are connected to the appropriate resources.

Family First Act implementation is supporting larger systems change efforts.

States view the Family First Act planning and implementation as increasing the focus on efforts related to prevention in their states. Examples of positive momentum spurred by the Family First Act in each state include:

- All six states are **expanding services for families**, often by building on existing service infrastructure.
- Nebraska and New York described ways in which the Family First Act has **strengthened cross-system communication and coordination** by bringing together new partners and requiring collaborative problem-solving.
- Washington and Michigan are **strengthening casework practice** by training caseworkers in Motivational Interviewing, and Colorado and South Carolina also described training and informational resources to enhance case managers' knowledge about prevention and available services.
- Colorado has **strengthened data capacity**, with the Family First Act helping to facilitate data sharing across systems such as Medicaid, early childhood, and behavioral health.
- New York is creating a new Center for Excellence to **support implementation of EBPs** and support external communications.

States have faced challenges implementing the Family First Act.

As states described their planning and implementation stages for Family First, four states (CO, NE, SC, WA) identified general challenges related to the steep learning curve and limited understanding of Title IV-E as a prevention funding stream, both within and outside the child welfare agency. One state (NE) described the pressure they felt to develop their plan quickly, as their alternative response program (e.g., safety plans that utilize community resources rather than removal from home) was funded under their expiring Title IV-E Waiver. Two states (NE, WA) described the importance of making ongoing revisions to their Prevention Plans, recognizing that this is an iterative process, as more programs are reviewed by the Clearinghouse and states have greater opportunities to engage more stakeholders, including individuals with lived expertise, in their ongoing Family First Act planning.

State perspective: New York

"There's so much opportunity to bring prevention to the front, and we know there are complexities around [FFPSA], it needs to be thought through, and some systems work done. From our perspective, that's where the big opportunity for FFPSA is."

Through our conversations with states, several specific challenges, detailed below, emerged in Family First Act implementation. Some of these challenges can and are being addressed in different ways in the states, with examples of their solutions described below. Others are specific to the Family First Act's legislative language and cannot be addressed without policy changes (e.g., the types of prevention programs eligible for federal reimbursement and the evidence requirements).

Misalignment between approved evidence-based programs (EBPs) and families' needs

All six states identified one or more of the following challenges:

Prevention Plans do not address families' concrete needs. Four states (CO, MI, NY, SC) identified the importance of meeting families' concrete needs--including economic security, housing, food, and child care--for preventing maltreatment, as well as the tension that these supports are not eligible for reimbursable under the Family First Act.

State perspective: New York

"We've been talking a lot about providing concrete supports, and we've heard from families they don't always need a service but a concrete support, when the washer has broken down, the car has broken down, food for the rest of the month, housing… the funding that's been made available even with Family First is solely aimed at a service such as all the different therapies. Those are great and needed but a lot of families need that concrete support to get through the month. So looking for more flexible funding that can be used in that manner is something that we would like to see happen on the federal level."

Few culturally responsive EBPs are eligible for reimbursement. Four states expressed concern regarding the lack of programs on the Clearinghouse that specifically serve families of color, and Black, Indigenous, or Hispanic families in particular. They pointed to the importance of allowing flexibility to adapt the models to be more culturally responsive and not taking a "one size fits all" approach. The evidence standards required by the Clearinghouse may be cost- and time-prohibitive for some programs and communities, while also not aligning with communities' traditional approaches to knowledge- and evidence-building. Two states also described processes of engaging Tribal partners in prevention service planning, only to have one or none of the programs of interest identified by the Tribes be rated as an EBP by the Clearinghouse. Washington leveraged state dollars outside of Family First Act to develop a pilot program for culturally responsive prevention services specifically for Indigenous and African American children. The pilot program for Indigenous children and families includes programs of interest identified in partnership with Tribes and will be delivered through culturally and physically proximate providers that are trusted in the community.

Other desired prevention programs, including some longstanding programs in states, are not eligible for reimbursement. States identified programs they would like to implement under Family First Act that do not currently meet criteria. With recognition that Family First Act funds just one part of the prevention services continuum, states have been creative in using private, state, local and other federal funding sources to fill gaps in their service array. For example, Nebraska reports a strong statewide implementation structure for Circle of Security with positive outcomes; however, the study completed by the state and other evaluations do not meet Clearinghouse standards. As a result, Nebraska is using sources such as private funding and federal Child Care and Development Funds to fund the program. Similarly, South Carolina described taking a holistic view of the state's service array, using non-Family First Act funding to implement concrete support programs and non-EBPs. Washington DCYF is also working to streamline its procurement process which has historically posed barriers for smaller providers competing for contracts.

State perspective: Nebraska

"I would love to see that [Tribes]… wouldn't have to go to the effort of proving that the traditional methods that they're used to using for prevention are valid, that they're effective. Like it's stuff that they've been doing for hundreds of years that have been prevention methods. Now they're being asked to invest hundreds of thousands of dollars to prove to somebody in an office in Washington, DC how their methods work."

Capacity constraints for implementing EBPs.

Among those EBPs that meet both Family First Act criteria and families' needs, states report a number of challenges to implementation. Starting and expanding programs in rural areas has been challenging due the geographical disbursement of families, lack of provider agencies, and challenges recruiting and retaining a workforce who meet the education and training requirements for the identified EBPs (CO, NE, SC). As one respondent described: *"best of luck to the person trying to get a masters level clinician to go to a rural area of the state where they may have to travel 200 miles to get to a client in need."* The need for a trained and culturally proximate workforce extends beyond rural areas. Clinicians who are trained specifically to work with infants and toddlers, as well as bilingual staff, can be challenging to find. Overall, respondents pointed to the general expense of EBPs (e.g., initial and ongoing training and support from the model purveyor) as a barrier to use.

State perspective: South Carolina

"I think the biggest struggle for our evidence-based practices is there weren't enough services and the evidence-based services that we have in our plan, a lot of them didn't exist here. And so it took a lot of capacity building, funding just to bring a few services to South Carolina. And then, when you're starting a service up with a purveyor, I could go on and on about all the challenges where you have when someone quits, then you have to start back over, and the cost just to train one person when there's recidivism is just, you know, crazy. I think building the capacity has been the biggest challenge. And that's why we've also thought critically or thought carefully about how to add other things."

Strategies employed by states to address these challenges include:

- **Leveraging existing programs.** All of the six states built their Family First Act plans, at least in part, around existing program capacity in the state. While in some instances states are standing up new programs, many chose to leverage and expand existing infrastructure to serve more families.
- **Using federal and philanthropic funds to build capacity.** Colorado, South Carolina, and Washington used Family First Transition Act [FFTA] funding to build provider capacity in specific EBPs such as Parents as Teachers. Recognizing that existing providers had full caseloads and would need additional staff to serve an increased number of referrals to home visiting services from the child welfare agency, South Carolina has also used philanthropic funding to hire additional parent educators for a few months until those parent educators are operating at full caseloads that can be reimbursed through Title IV-E.
- **Paying differential rates for service delivery in rural areas** to offset increased administrative costs and additional travel time (NE).
- **Creating a "Center for Excellence"** at the state level to support the implementation of EBPs (NY).

Administrative hurdles facing state child welfare agencies and providers

Four of the six states (NE, NY, SC, WA) identified administrative hurdles that pose Family First implementation challenges at the state and/or provider level. Two states (NY, WA) reported that these hurdles have prevented them from claiming for Title IV-E reimbursement, and Colorado estimated that it would take approximately 18 months to build out its infrastructure to support future reimbursement through the Family First Act. Administrative challenges fall into three primary categories:

- **Contracting for services.** Prevention services such as home visiting and early learning programs, which have traditionally been procured outside of the child welfare agency, pose unique contracting challenges. For example, in Washington, while child welfare and early learning are now both under the umbrella of the Department of Children, Youth, and Families (DCYF), the contracts systems have not been integrated across these two arms of the agency. Providers therefore need to apply through two systems to deliver the same services, and agency administrators are unable to see a comprehensive list of organizations already contracted to provide a particular program. Further, to ensure separation of funding streams, home visiting providers have historically been disqualified for funding in DCYF's Strengthening Families Washington portfolio if they serve child welfare involved families.

State perspective: Washington

"I think you'll see in many jurisdictions that there's a balance between offering services in a voluntary sense and also having your information collected by the Title IV-E agency. I think that's the struggle that we have had in some of our home visiting discussions. We don't currently capture that data in the Title IV-E system - which I think most jurisdictions don't. So what's the balance between capturing the data that's necessary to claim for funding purposes, but also ensuring that the families in the populations that we're serving have their information seen in a way that's respectful to where they're at."

- **Billing for services.** While braiding together funding sources can increase families' access to prevention services, the requirements of the different sources can pose administrative challenges for both the providers and the public state agencies administering the funds across all six states. Restrictions and requirements for each funding source vary, as do the monitoring and billing systems used across agencies and divisions. This necessitates close collaboration across partners to procure services and support those service providers receiving funds from more than one public agency (e.g., both the child welfare and health departments). Agency administrators also described changes to contract types (e.g., from slot-based to fee-for-service, implementing new case rates) to meet funding reporting requirements.
- **Gathering and reporting the required data in a way that protects families' privacy.** Child welfare agencies across all states are grappling with how to gather information on families served through Family First, particularly in instances where the family does not have an open child welfare case. Further, Washington's data system does not currently indicate whether a young person in foster care or served by juvenile rehabilitation is a parent (two populations who are candidates for foster care in the state).

To navigate these administrative hurdles, states are taking actions such as developing new administrative tools for providers (e.g., Nebraska) and conducting feasibility studies of alternative ways to collect needed data to claim reimbursement. For example, Washington described contracting with a service navigation agency to collect data on its pilot prevention programs outside of the state's child welfare data system.

Insufficient coordination between family-serving agencies

While the Family First Act has spurred new and deepened existing collaborative partnerships in all six states, three states (NY, SC, WA) pointed to the need for greater coordination. In some instances, key partners (e.g., Medicaid, the Early Childhood Advisory Council) have not been regularly engaged in Family First Act planning conversations. For example, in one state, a respondent highlighted the opportunity for the child welfare agency, which is driving Family First Act planning, to better coordinate with the state early learning agency, which has an extensive network of relationships with community-based organizations and Tribes. This gap was evident in our recruitment for this study as well; some individuals were hesitant to participate because they did not see their work as directly related to Family First but rather prevention more broadly.

To address these challenges, respondents recommended taking an inclusive prevention planning approach that engages key partners, including families with lived expertise and stakeholders outside of child welfare, from the very beginning.

Supporting frontline staff through practice changes

Two states (SC, WA) described the challenges frontline staff have faced with Family First Act implementation and the importance of providing support and reinforcing practice changes. Specifically, they described the need to shift child welfare agency culture to prioritize prevention. For example, as South Carolina has built out its prevention service array, it noted the importance of supporting a mindset and cultural shift among frontline staff and supervisors to increase the focus on high quality services (e.g., shifting from referring families to a known service provider with availability to identifying the EBP that most closely aligns with a families' strengths and needs). Washington views training in Motivational Interviewing as a key component of its practice change; however, there have been challenges with implementation (e.g., existing constraints on case managers' time to implement a new practice). It is also important to cross-train child welfare case managers and service providers on each other's work and new referral pathways.

To support casework practice and facilitate agency culture change, South Carolina developed a decision support tool that uses families' assessment results to identify which of the state's evidence-based programs would best support the family based on their individual strengths and needs. The tool is intended to support case managers navigate newly available services and minimize decision fatigue. South Carolina has seen success in identifying champions for specific EBPs in local offices who encourage referrals via word of mouth. Washington also recognizes the importance of ongoing support to promote practice changes and is using external consultants to support uptake of Motivational Interviewing. More broadly, Washington has a staff member who serves as a Family First Act Program Consultant, with a focus on supporting the agency's cultural shift toward developing a prevention-oriented mindset.

Discussion and Recommendations

Across all six states, our interviews painted a clear picture of state leaders who recognize the critical need for prevention services for families with infants and toddlers. Each state described their commitment to expanding the services they have now – both in reaching new families with well-established programs like home-visiting, and in providing new supports for families that are community-based and delivered by their peers. States also recognized that access to concrete supports, such as housing and financial assistance, are vital to supporting the healthy development of children and parents' ability to provide the type of care children need to be safe and thrive. They see prevention as essential to making child welfare systems more equitable. They are also eager to learn from parents and caregivers who have experience with the child welfare system to ensure services and supports are accessible and are tailored to meet needs.

It is also clear that each state is in a period of great change and transformation. From new agencies and restructured departments, to new advisory groups, to new cross-agency partners – the priorities and decisions being made by systems are rapidly changing the service array. The Family First Act has been at the center of much of that change: creating new opportunities to bring previously siloed systems together to plan a more coordinated approach to prevention and providing child welfare systems with a new designated funding source for prevention. It has allowed states to create new partnerships and invigorated existing collaboration efforts. However, states also noted that existing relationships, programs, and infrastructure focused on prevention enable them to better act upon and utilize the resources that Family First Act offers. There are still major barriers to meeting the needs that families and communities have identified as necessary to reduce child welfare agency involvement. There has been increased awareness of what families really need and how siloed and disjointed services are. Focusing primarily on evidence-based interventions and limiting flexible supports for concrete needs is a mismatch for families and reduces our effectiveness at preventing child maltreatment.

Because our study began with consulting child welfare administrations, and the connections to other entities were facilitated by the child welfare agency, this study uplifts many of the successes, barriers, and challenges happening within child welfare agencies. As they struggle with Family First Act implementation challenges – such as a lack of qualifying EBPs that meet the needs of families, to overall limited funding sources – this is a critical time to support states in their prevention efforts.

It is exciting, however, that the study did not stop with the child welfare system. We connected with many non-child welfare agencies and initiatives that do the work of prevention. As described in this report, there are many new and unexpected partnerships and relationships – and involve strategic planning, braiding funding, and making services delivery more cohesive. Although these partnerships were central to much of the innovation in prevention work identified in this study, every state told us that relationship building is time consuming and difficult work, particularly in times when staff and budgets are strained. We also heard from them that this work is worth the effort and that aligned and integrated systems support families in accessing the services they need.

This study also focuses in on understanding ways that child welfare systems may be specifically addressing the needs of young children and families, as well as how child welfare and early childhood systems partner and collaborate. We learned about many bright spots. In particular, home visiting has served as a nexus for creating new and constructive partnerships between agencies and expanded services for families with Family First implementation. However, the challenges that arise with collaboration, availability of services, and a strained workforce can be particularly damaging to the developmental needs of infants and toddlers.

Recommendations for state leaders

Strong families produce positive outcomes well beyond simply preventing abuse or neglect. Ensuring that early childhood development is on track, improving mental health for both parents and children, reducing stress, and increasing economic security are all important outcomes that a child and family well-being system can help promote. Findings from this report show that persistent gaps remain: there are few policies that address the unique needs of families with very young children and support parents in navigating and accessing the array of supports they need to be strong nurturers of their children.

As state leaders across the nation increase investments in prevention and promotion and strive to create systems that tap into the strengths of families and communities, we encourage them to consider the unique needs of families with very young children. Based on the findings from this report, we recommend the following to states to best support the unique needs of infants, toddlers, and their families:

Recommendations for supporting the alignment and coordination of prevention efforts, from development, to funding, to implementation

Reduce silos that exist between systems and broaden the stakeholders coming together to focus on prevention and promotion. States in this study shared a broad group of potential partners – going far beyond just traditional child welfare service providers. By integrating these siloed systems states can enhance how families are supported before problems occur or escalate, with readily available resources being invested in needed areas and the adoption of strategies that build protective factors across the community and state. Coordination and alignment between health and early learning systems can help promote important statewide goals such as improving healthy development, early learning, and the well-being of children. One way states can do this is by leveraging existing interagency coordinating structures such as State Advisory Councils (SACs) on Early Childhood Education and Care or Children's Cabinets.

Strengthening Families with Infants and Toddlers: A Policy Framework for States

The **ZERO TO THREE Infant-Toddler Court Program National Resource Center** has developed a policy framework with 11 recommendations for states and communities that aim to advance equitable outcomes supporting the health and well-being of infants and toddlers and their families, including those who are in or are at risk of entering the child welfare system. The report provides state and local policymakers with a roadmap to develop and advance policies that will drastically improve the systems and supports families with young children need to thrive and create protective factors that promote resilience, highlighting strategies on how to infuse family strengthening, child development and parent voice into child welfare systems.

Create central access points for families that are community-based and can provide a range of services and concrete supports to help strengthen families and increase protective factors. Many families with young children face multiple barriers to accessing services that can negatively impact a child's development (e.g., geographic disparity in service/provider availability, lack of transportation, limited English proficiency). Community access points that are easily identifiable to families and provide a range of services, including navigation supports to help families access eligible benefits and services that can help families who may be in crisis or need additional support. For example, Family Resource Centers are community-based resource hubs where families can access a range of formal and informal supports and services to increase parenting skills and protective factors. As recognized by states in this report, access to concrete supports, such as housing and financial assistance, are vital to supporting the healthy development of children and parents' ability to provide the type of care children need to be safe and thrive. States should also fund enabling services, such as transportation and child care services, that can help bridge this gap by making it easier for families to participate, which can help promote better health and well-being outcomes.

Recommendations to support the broad accessibility of prevention and promotion services that meet the unique needs of families with young children

Increase system capacity to support families with young children early before a crisis occurs, to prevent families from moving deeper into intervening systems. As discussed in this report, access to services is specifically important for families with infants and toddlers, as this is the period when the brain undergoes its most dramatic development as children acquire the ability to think, speak, learn, reason, and relate to others. Robust services for families with young children can maximize upstream prevention efforts and reduce reliance on more intensive secondary or tertiary prevention down the road. Resources like ZERO TO

THREE's Supporting Sustainability For Infant-Toddler Court Teams: A Federal Funding Guide can help states understand what funding is available for such services.

Build a high-quality child welfare workforce that is trained in the science of early childhood development and utilizes infant mental health specialists to support child welfare agencies. Infant and early childhood mental health specialists are one example of those who can serve as consultants to staff, birth parents, and other caregivers and can help address the relationship between baby and parent and/or between baby and resource parent. These specialists can provide case consultation and reviews of cases of infants and toddlers in child welfare to ensure the use of best practices in child development.

Recommendations for promoting equity and incorporating parent voice in prevention planning and implementation

Center family and provider voices by creating a network of family support partners, mentors, and parent leaders who have lived experience with prevention and child welfare systems. Integrate the lived expertise of families - including parents and relatives, kinship caregivers, and young people who have experienced foster care – into every aspect of prevention planning, implementation, and evaluation. Key among these is the importance of involving parents with lived expertise in designing policies, practices, and systems so they are easier to use and reflect the knowledge that parents have in navigating systems. As described in this report, families have informed the foundational planning period by identifying service needs and gaps, providing critical services directly to families facing challenges, supporting implementation of initiatives by developing engagement resources for communities, and sharing feedback on how well implementation is working. Lived experts should be compensated for their time and states should develop mechanisms for lived experts to understand how their feedback and insights have helped shape policy and practice.

Leverage data in efforts to build systems that welcome and affirm all people and parents. First and foremost, data should be collected and analyzed to identify disparities and understand the barriers, circumstances, and conditions affecting families. By continuously reviewing data and making improvements to policies and practices, state agencies can make progress in addressing systemic racism and improve the well-being of children and families. For example, states can review their current child welfare investigation and child removal policies to change punitive practices that contribute to over-surveillance of families of color and equate poverty with neglect. To better understand what is driving these disparities, states should disaggregate their data for young children under age three and look at key trends and decision points—particularly unsubstantiated reports of maltreatment, child welfare contact, or involvement by race and ethnicity and geography. States and communities can then use this data to deploy services and resources to communities with the largest disparities.

Although states have faced implementation challenges with the Family First Act, it is playing a unique and important role in overall prevention efforts

Be intentional about drawing down funding for services and supports than can help families meet concrete needs such as housing, food, and transportation in an effort to keep families from entering the child welfare system. While there are many funding sources available to states and child welfare agencies, each funding stream has its own limitations and requirements, and no single source or even creative patchwork of funding remains fully adequate to meet the needs of families. States should work across agencies to determine what funding is available that can help meet families to meet concrete needs and create strategies to enable that funding to reach communities and families that could most benefit from these efforts by reducing unnecessary and traumatic separation of young children from their parents.

Create more opportunities through the Family First Act to fund programs that meet the diverse needs of all families, including culturally relevant programs. While the Family First Act is an important funding stream in support of keeping families together at home, there is further work to be done at the federal level to ensure that services are truly providing the support families need. Giving states more flexibility in reimbursement for delivering culturally appropriate services, while continuing to build the evidence base, honors the diverse needs of families. Expanding the cultural adaptation of programs and expanding eligible programs within the Title IV-E Prevention Services Clearinghouse—particularly those that have been designed for families of color, and Black, Indigenous, or Hispanic families in particular—can help ensure equal access for all families.

Conclusion

States described this time of change with great optimism. They see a clear path to a stronger prevention system in the coming years. We hope this report can help states at every stage of their prevention and promotion work, as they learn from the strategies, challenges, and success of the six states featured in this study. We also urge researchers and funders to continue to expand the research base around prevention and promotion. Although this study provides a foundational understanding of the work in these six states, we were limited in our ability to speak directly to the parents who receive services or inform policy, and directly with Tribal leaders who are also doing related work – both of which are incredibly important perspectives in understanding strengths and gaps in promoting and nurturing strong families.

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